AMCP
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April 29, 2024

Chiquita Brooks-LaSure
Administrator
Centers for Medicare & Medicaid Services
Department of Health and Human Services
Office of Strategic Operations and Regulatory Affairs
Division of Regulations Development
7500 Security Boulevard
Baltimore, MD 21244–1850

Submitted electronically via regulations.gov

Re: The Medicare Advantage and Prescription Drug Programs: Part C and Part D Medicare Prescription Payment Plan Model Documents (CMS–10882)

Dear Administrator Brooks-LaSure:

The Academy of Managed Care Pharmacy (AMCP) thanks the Centers for Medicare & Medicaid Services (CMS) for the opportunity to provide comments in response to "The Medicare Advantage and Prescription Drug Programs: Part C and Part D Medicare Prescription Payment Plan Model Documents" (Model Documents), issued on February 29, 2024.

AMCP is the nation's leading professional association dedicated to increasing patient access to affordable medicines, improving health outcomes, and ensuring the wise use of healthcare dollars. Through evidence and value-based strategies and practices, AMCP's nearly 8,000 pharmacists, physicians, nurses, and other practitioners manage medication therapies for the 270 million Americans served by health plans, pharmacy benefit management firms, emerging care models, and government health programs.

AMCP and its members commend CMS for supporting plan sponsors in their efforts to implement the requirements of the Medicare Prescription Payment Plan (MPPP). The Model Documents provide much needed clarity for plan sponsors on how they can meet the regulatory requirements when communicating with beneficiaries about the MPPP. AMCP encourages CMS to further simplify the language in the Model Documents to meet the needs of beneficiaries with limited literacy, limited health literacy, or limited English proficiency. Educational materials on the MPPP should consistently incorporate clear and concise language and multiple language translations to ensure the information is understood by everyone.

AMCP and its members also suggest the development of additional educational resources such as cost calculators and other decision tools to provide beneficiaries with greater insights into potential out-of-pocket costs savings when enrolling in the MPPP.

AMCP appreciates your consideration of the concerns outlined above and looks forward to continuing work on these issues with CMS. If you have any questions regarding AMCP's comments or would like further information, please contact AMCP's Manager of Regulatory Affairs, Vicky Jucelin, at vjucelin@amcp.org or (571) 858-5320.

Sincerely,

Susan A. Cantrell, MHL, RPh, CAE
Chief Executive Officer

April 29, 2024

Dr. Meena Seshamani
Deputy Administrator & Director of the Center for Medicare
Centers for Medicare & Medicaid Services
7500 Security Boulevard
Baltimore, MD 21244

Re: Medicare Prescription Payment Plan Model Documents

Dear Deputy Administrator Seshamani:

The American Cancer Society Cancer Action Network (ACS CAN) appreciates the opportunity to comment on the model documents for the implementation of the Medicare Prescription Payment Plan (MPPP). ACS CAN is making cancer a top priority for public officials and candidates at the federal, state, and local levels. ACS CAN empowers advocates across the country to make their voices heard and influence evidence-based public policy change, as well as legislative and regulatory solutions that will reduce the cancer burden. As the American Cancer Society's (ACS) nonprofit, nonpartisan advocacy affiliate, ACS CAN is more determined than ever to end cancer as we know it, for everyone.

In 2024, more than 2 million Americans are projected to be diagnosed with cancer.[1] Over 1 million of those diagnosed are age 65 or older and rely on the Medicare program as their primary source of health care coverage.[2] Millions of Medicare beneficiaries will benefit from the Medicare Prescription Payment Plan program but given its optional nature it is vitally important that CMS, working with stakeholders including plans, providers, and patient and consumer organizations work together to ensure that Medicare beneficiaries are provided clear, accurate information about the program and how to enroll.

Broad Education Needed

Survey Findings: In a recent ACS CAN *Survivor Views* survey, we asked Medicare beneficiaries and their caregivers whether they were aware of the option to cap their monthly Part D out-of-pocket costs beginning in 2025 and only 4% of respondents indicated they had heard anything about the new program and 82% of respondents indicated they were unaware of the new program.[3] This demonstrates that significant education and outreach is needed to inform beneficiaries of this optional new program.

Material Development: In addition to the model forms, CMS will need to develop educational materials to help inform beneficiaries about this new program and who will benefit from enrolling. We strongly encourage CMS to develop decision tools, such as cost calculators and decision aids, which will better demonstrate to beneficiaries how they could personally benefit if they enroll in the MPPP program. We strongly encourage CMS to make

[1]. American Cancer Society. *Cancer Fact & Figures 2024*. Atlanta: American Cancer Society; 2024.
[2] U.S. Cancer Statistics Working Group. U.S. Cancer Statistics Data Visualizations Tool, based on 2022 submission data (1999-2020): U.S. Department of Health and Human Services, Centers for Disease Control and Prevention and National Cancer Institute; https://www.cdc.gov/cancer/dataviz, released in November 2023.
[3] American Cancer Society Cancer Action Network *Survivor Views* Survey. N=766 cancer patient and survivor Medicare beneficiaries, January 3-22, 2024. https://www.fightcancer.org/sites/default/files/national_documents/prespaymplan.pdf.

these materials available on the Medicare.gov website and to provide prominent placement of these materials.

In addition, we encourage CMS to develop materials for stakeholders to use to educate beneficiaries. These materials should be available in a variety of formats including information designed to be printed and shared with beneficiaries and educational materials designed to be shared via social media. Many stakeholders will choose to use CMS materials (to ensure accuracy of information and consistency of message) and it is important that CMS provide an array of options.

ACS Patient Navigation: Beginning January 1, 2024, Medicare Part B now provides reimbursement for principal illness navigation (PIN) services. ACS CAN and ACS strongly support reimbursement for these services, which have been shown to provide additional support to cancer patients and their families by helping lessen the caner burden during and after treatment. As part of our commitment to increase access to patient navigation services, ACS has launched a new oncology professional navigator curricula and certification program that will provide critical technical training and certification for those who provide PIN services. As part of these efforts, ACS will include in their training modules information about the MPPP program, using educational materials developed by CMS. Integrating MPPP information into the professional navigator curriculum will provide yet another outlet in which to educate Medicare beneficiaries via patient navigators.

Concerns About Fraud: While additional education and outreach is needed, we are concerned about the potential for unscrupulous actors to use the launch of the MPP to defraud beneficiaries. As CMS launches the MPPP program, we encourage the agency to increase their anti-fraud activities and shut down any fraudulent activity as soon as possible.

Comments on Specific Documents

We support many of the materials CMS has developed to educate beneficiaries about the MPPP program. Overall, we would encourage CMS to clearly note in all its materials three important facts:

1. The MPPP program is an optional program that is provided in addition to the Medicare Part D benefit. A beneficiary does not disenroll in Part D when they choose to opt into the MPPP program;
2. The MPPP program is an optional benefit for all Part D plans. A beneficiary does not have to change their existing Part D election in order to take advantage of the benefits of the MPPP program; and
3. Beneficiaries do not have to pay a separate fee to join the MPPP program.

We are concerned that the materials as drafted by CMS fail to mention these important points and as such may give the erroneous impression to beneficiaries that they have to change their existing Part D elections in order to take advantage of the benefits of the MPPP. Clarifying these points will also help to reduce fraud as some unscrupulous actors may lie to beneficiaries, telling them they have to enroll in a specific Part D plan and/or pay a fee in order to enroll in the MPPP.

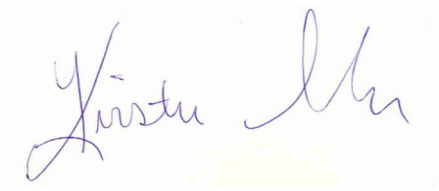
We offer the following specific comments on the draft materials:

- **MPPP Election Request Form**: We would encourage CMS to provide additional information about the MPPP (for example, using the language under the "What's the Medicare Prescription Payment Plan?" question included in the Likely to Benefit Notice). We are concerned that without additional information, beneficiaries may not have a proper understanding about the MPPP before they enroll. We would also recommend that this notice direct beneficiaries to Medicare.gov or 1-800-MEDICARE as a resource for additional information.

Conclusion

We thank CMS for offering the opportunity to comment on the model documents for the implementation of the MPPP. We stand ready to work with CMS to develop materials that will help to educate enrollees and stakeholders about the option and what the enrollees' responsibilities are when they make that election. If you have any questions, please feel free to contact me or have your staff contact Anna Schwamlein Howard, Policy Principal, Access and Quality of Care at anna.howard@cancer.org.

Sincerely,



Kirsten Sloan
Managing Director, Public Policy
American Cancer Society Cancer Action Network

American Lung Association.

April 29, 2024

The Honorable Chiquita Brooks-LaSure
Administrator
Centers for Medicare & Medicaid Services
Department of Health and Human Services
7500 Security Blvd
Baltimore, MD 21244

RE: The Medicare Advantage and Prescription Drug Programs: Part C and Part D Medicare Prescription Payment Plan Model Documents (CMS-10882)

Dear Administrator Brooks-LaSure:

Thank you for the opportunity to provide comments on the Medicare Prescription Payment Plan (MPPP) model documents.

The American Lung Association is the oldest voluntary public health association in the United States, representing the more than 34 million individuals living with lung disease. The Lung Association is the leading organization working to save lives by improving lung health and preventing lung disease through research, education and advocacy.

Approximately 25% of seniors report difficulty affording their medications and three in ten adults have not taken their medication as prescribed due to costs.[1] The Lung Association strongly supported the out-of-pocket (OOP) cap in Medicare Part D and related policies to spread patients' prescription drug costs over the year included in the Inflation Reduction Act (IRA). If implemented well, these policies will be an important step forward in improving the affordability of medications for seniors in Medicare Part D, especially for people with lung disease who often rely on multiple medications to manage their conditions. The Lung Association looks forward to working with you on the implementation of these policies and offers the following comments on MPPP model documents.

A strong set of model document documents is crucial to the success of the MPPP, and the Lung Association urges CMS to finalize the model materials as soon as possible. Overall, the model documents are clear and understandable, but additional clarifications are needed to help to reduce patient and consumer confusion about this new program. First, the removal for failure to pay document should include specific instructions for individuals on how they can re-enroll in the MPPP once they have made any overdue payments. Additionally, CMS should incorporate information into the model materials that help patients and consumers recognize official correspondence from their plan about the MPPP. This would help to reduce the risk of fraud, which is especially important in the first year of this new program.

The model documents are also an important opportunity to educate patients about other benefits in Medicare Part D that can help to reduce their costs. For example, the IRA included provisions that eliminate cost-sharing for recommended vaccines for seniors with Medicare Part D coverage. Including information about this benefit in the section on "are there programs that can help lower my costs" in the election approval notice and other similar materials could help to improve uptake of this benefit and reduce the burden of vaccine-preventable diseases for seniors.

The Lung Association recommends that CMS supplement these model documents with practical examples that can help patients understand whether this program makes sense for them. Examples could include hypothetical patients who have a high prescription drug costs early in the year that will lead them to quickly reach the OOP cap and likely benefit from the program, as well patients who have lower, fairly regular prescription drug costs throughout the year who might not benefit from enrollment. Additionally, the Lung Association continues to recommend that CMS develop online calculators and other similar tools that allow patients to input expected prescription drug costs, tools which could then be referenced in these materials. These types of resources would provide the type of meaningful, actionable information that patients need to determine the benefit of the MPPP for their individual situation.

As the Lung Association highlighted in previous comments on MPPP implementation,[2] all model documents should be accessible for people with limited English proficiency as well as people with disabilities. Simply translating documents or complying with technical standards is often not sufficient to ensure access, and content may need to be adapted to ensure people with limited English proficiency and disabilities fully understand the program. Additionally, accessible materials must be part of a broader effort to reach underserved populations, including partnering with patient and community organizations with relevant expertise to educate patients about the MPPP.

Finally, the Lung Association underscores the importance of CMS launching a broad outreach and enrollment campaign to help patients and other stakeholders understand the OOP cap and their ability to spread payments out over a calendar year. Recent polling suggests that only one third of seniors are aware of the upcoming annual OOP prescription drug limits for people with Medicare coverage.[3] We encourage you to work with patient groups and their call center staff, state health insurance assistance programs and other key organizations in the patient and consumer advocacy communities to maximize their networks and outreach, as well as health plans, pharmacies, provider organizations and other stakeholders.

Thank you for the opportunity to provide these comments. We look forward to continuing to partner with you on the implementation of these critical policies to help reduce patients' prescription drug costs in Medicare.

Sincerely,

Harold P. Wimmer
President and CEO

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[1] KFF, Public Opinion on Prescription Drugs and Their Prices. Updated August 21, 2023. Available at: https://www.kff.org/health-costs/poll-finding/public-opinion-on-prescription-drugs-and-their-prices/.

[2] American Lung Association, Comments to CMS re Medicare Prescription Payment Plan Guidance, Part 2. March 15, 2024. Available at: https://www.lung.org/getmedia/2f9ad85b-00bc-4084-bb05-77ebfcdefe7d/American-Lung-Association-MPPP-Guidance-Comments-Part-2-FINAL.pdf.

[3] KFF, KFF Health Tracking Poll July 2023: The Public's Views Of New Prescription Weight Loss Drugs And Prescription Drug Costs. August 4, 2023. Available at: https://www.kff.org/health-costs/poll-finding/kff-health-tracking-poll-july-2023-the-publics-views-of-new-prescription-weight-loss-drugs-and-prescription-drug-costs/.

AMERICAN SOCIETY OF HEMATOLOGY
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April 26, 2024

Meena Seshamani, M.D, PhD
CMS Deputy Administrator and Director of the Center for Medicare
Center for Medicare
7500 Security Boulevard
Baltimore, MD 21244-185

Re: Medicare Advantage and Prescription Drug Programs: Part C and Part D Medicare Prescription Payment Plan Model Documents

Dear Deputy Administrator Seshamani:

The American Society of Hematology (ASH) appreciates the opportunity to submit comments pertaining to the model communication documents for the Medicare Prescription Payment Plan (MPPP). The MPPP program aims to improve health care accessibility and affordability by offering enrollees the option to pay for their out-of-pocket drug costs over a plan year instead of paying high costs upfront at the pharmacy. As part of ASH's longstanding commitment to improving the accessibility and affordability of high-quality, clinically appropriate care, including innovative drug and gene therapies, the Society submitted comments on the Part Two Draft Guidance for the MPPP program. In the comments, ASH shared general support for the program and recommended that the Centers for Medicare & Medicaid Services (CMS) draft communication documents that physicians can use in their practice to support education and outreach efforts for this program.

ASH represents more than 18,000 clinicians and scientists worldwide committed to studying and treating blood and blood-related diseases. These disorders encompass malignant hematologic disorders such as leukemia, lymphoma, and multiple myeloma, as well as classical (or non-malignant) conditions such as Sickle Cell Disease (SCD), thalassemia, bone marrow failure, venous thromboembolism, and hemophilia. In addition, hematologists are pioneers in demonstrating the potential of treating various hematologic diseases and continue to be innovators in the fields of stem cell biology, regenerative medicine, transfusion medicine, and gene therapy. ASH membership is comprised of basic, translational, and clinical scientists, as well as physicians providing care to patients.

ASH appreciates the opportunity to emphasize support for the MPPP program and the importance of model communication documents for patient education and outreach that might occur in practice settings. ASH believes that these documents will help physicians engage in patient education, as physicians will likely be trusted advisors for their patients when evaluating participation in this program. These documents will help general understanding of the applicability of the program and how the program will function, specifically the "Likely to Benefit Notice" and the "Notice of Election Approval" documents will be helpful for patients when considering enrollment.

ASH also appreciates the opportunity to share recommendations to strengthen the model communication documents. ASH recommends the inclusion of tools related to patient payment calculation in the communication materials. A patient payment calculator would help assist

patients in understanding how program benefits may apply and would allow patients to see how their costs may "smooth" over a plan year. A patient's monthly bill calculation may be complex depending on when the patient enrolls in the program, the patient's initial out-of-pocket payments, and any new costs they may incur in the plan year; a calculator designed to process these inputs could help simplify the calculation process. Additionally, unique inputs for payment calculation may come up more frequently in hematology, as patients have no way to plan for a rare hematologic diagnosis that may require a high-cost therapeutic. In this instance, a patient payment calculator would allow for a hematology patient to tailor their exact circumstances to the program in the calculator and understand how this program would directly impact their out-of-pocket costs.

Additionally, including more clarifying examples about the nuances of this program throughout the communication documents would strengthen understanding of how the program will be implemented and how a prospective enrollee may benefit. For example, there are two scenarios in this program in which additional examples may improve patient understanding of the program's impact; first, this program may provide cost-savings in addition to payment smoothing over a plan year for out-of-pocket costs above $2000, and second, this program would only provide smoothing over a plan year for out-of-pocket-costs under $2000. This distinction is important for patients to understand in what way they may benefit. ASH therefore recommends additional examples be incorporated in layperson's terms throughout the communication documents.

Lastly, ASH recommends elevating the different mediums by which patients can access more information. While the websites are referenced in the communication documents, the phone numbers are not featured as prominently, and some seniors may have limited web access. To address this potential barrier, ASH recommends that both the websites and phone numbers be highlighted more prominently in the communication documents. Also, ASH urges CMS to ensure that the appropriate staffing and resources are available for the maintenance of the websites and phone lines, so that beneficiaries can access additional information effectively and timely.

The Society appreciates the opportunity to share continued support for this program and recommendations to strengthen the draft the model communication documents. Should you have any questions or require further information, please contact Carina Smith, ASH Manager for Health Care Access Policy, at casmith@hematology.org.

Sincerely,

Mohandas Narla, DSc
President

Mary-Elizabeth M. Percival, MD
Chair, Committee on Practice

Consider Managing Your Monthly Drug Costs with the Medicare Prescription Payment Plan

You might benefit from participating in the Medicare Prescription Payment Plan, because you have high drug costs. This new payment option works with your current drug coverage, and it can help you manage your drug costs by spreading them across **monthly payments that vary throughout the year** (January – December).

What's the Medicare Prescription Payment Plan?

The Medicare Prescription Payment Plan is a new payment option to help you manage your out-of-pocket drug costs, starting in 2025. All Medicare drug plans and Medicare health plans with drug coverage (like a Medicare Advantage Plan) must offer this payment option, and all plans use the same formula to calculate your monthly payments. If you select this payment option, each month you'll pay your plan premium (if you have one) and you'll get a bill from your health or drug plan for your prescription drugs (instead of paying the pharmacy).

Participating in this payment option is voluntary. Anyone with a Medicare drug plan or a Medicare health plan with drug coverage can use this payment option, which applies to all prescription drugs covered by Part D. It doesn't cost anything to participate in the Medicare Prescription Payment Plan, and you won't pay any interest or fees on the amount you owe, even if your payment is late.

Will this payment option help me?

It depends on your situation. If you have high out-of-pocket drug costs, this payment option spreads out what you'll pay each month across the year (January – December), so you don't have to pay out-of-pocket costs to the pharmacy. **This payment option might help you manage your expenses, but it doesn't save you money or lower your drug costs.** Visit Medicare.gov/basics/costs/help/drug-costs to learn about programs that can help lower your drug costs.

How will my costs work with this payment option?

The new prescription drug law caps your out-of-pocket costs at $2,000 in 2025 and eliminates the coverage gap (known as the "donut hole"). This means you'll never pay more than $2,000 in out-of-pocket drug costs in 2025. **This is true for everyone with Medicare drug coverage, even if you don't join the Medicare Prescription Payment Plan.**

When you fill a prescription for a drug covered by Part D, you won't pay your pharmacy (including mail-order and specialty pharmacies). Instead, you'll get a bill each month from your plan. Your monthly bill is based on what you owe for any prescriptions you get, plus your previous month's balance, divided by the number of months left in the year.

Note: Your payments might change every month, so you might not know what your exact bill will be ahead of time. Future payments might increase when you fill a new prescription or refill an existing prescription because as new out-of-pocket drug costs are added into your monthly payment, there are fewer months left in the year to spread out your payments.

How do I know if this payment option might not be right for me?

This payment option might not be helpful for you if:

- You get Extra Help from Medicare.
- You qualify for a Medicare Savings Program.

- You get help paying for your drugs from other organizations, like a State Pharmaceutical Assistance Program (SPAP) or other health coverage.
- Your yearly drug costs are low.
- Your drug costs are the same each month.
- You're considering signing up for the payment option late in the calendar year (after September).
- You don't want to change how you pay for your drugs.

Who can help me decide if I should sign up for this payment option?

- **Your plan:** Visit your plan's website, or call your plan to get more information. Your plan's phone number is on the back of your membership card.
- **Medicare:** Visit Medicare.gov/tbd, or call 1-800-MEDICARE (1-800- 633-4227), 24 hours a day, 7 days a week. TTY users can call 1-877-486-2048.
- **State Health Insurance Program (SHIP):** Visit shiphelp.org to get the phone number for your local SHIP and get free, personalized health insurance counseling.

How do I sign up for this payment option?

To sign up for this payment option, visit your plan's website or call your plan. You can find your plan's phone number on the back of your membership card. If you need to pick up a prescription urgently, the fastest way to use this payment option is to call your plan.

Need this information in another format or language?

To get this material in other formats like large print, braille, or another language, contact your Medicare drug plan. If you need help contacting your plan, call: 1-800-MEDICARE (1-800-633-4227).

Biotechnology Innovation Organization
1201 New York Ave., NW
Suite 1300
Washington, DC, 20005
202-962-9200

April 19, 2024

The Honorable Chiquita Brooks-LaSure
Administrator
Centers for Medicare & Medicaid Services
Department of Health and Human Services
Attention: Medicare Prescription Payment Plan Model Documents
Baltimore, MD 21244–1810

Re: The Medicare Advantage and Prescription Drug Programs: Part C and Part D Medicare Prescription Payment Plan Model Documents (CMS-10882)

Dear Administrator Brooks-LaSure:

The Biotechnology Innovation Organization (BIO) appreciates the opportunity to comment on the Center for Medicare and Medicaid Services' (CMS's/the Agency's) Information Collection Request (ICR) on the Part C and Part D Medicare Prescription Payment Plan (MPPP) Model Documents.

BIO is the world's largest trade association representing biotechnology companies, academic institutions, state biotechnology centers, and related organizations across the United States and in more than 30 other nations. BIO's members develop medical products and technologies to treat patients afflicted with serious diseases, to delay the onset of these diseases, or prevent them in the first place. In that way, our members' novel therapeutics, vaccines, and diagnostics not only have improved health outcomes, but also have reduced healthcare expenditures due to fewer physician office visits, hospitalizations, and surgical interventions. BIO membership includes biologics and vaccine manufacturers and developers who have worked closely with stakeholders across the spectrum, including the public health and advocacy communities, to support policies that help ensure access to innovative and life-saving medicines and vaccines for all individuals.

As BIO has commented previously through the proposed Part 1 and Part 2 MPPP Guidance, the MPPP will be a critical benefit for patients to help them reduce the immediate financial strain of out-of-pocket costs. We appreciate CMS' development of the MPPP Model Documents and support CMS' ongoing efforts to facilitate education and outreach of the MPPP. As CMS continues to finalize guidance and develop resources on the MPPP, it is important that a robust toolkit of patient-centered materials be available to all Medicare beneficiaries so that any Medicare beneficiary as a potential enrollee can understand and utilize the MPPP. To that end, BIO offers the following suggestions to the Model Documents to ensure that the documents are clear, consistent, patient-centered, simple to understand, easily accessible, and minimize the potential for enrollee confusion.

Part D Sponsor Notice to Acknowledge Acceptance of Election in the Medicare Prescription Payment Plan

CMS' proposed Model Documents includes the following description: "Your payments may change every month, so you might not know what your exact bill will be ahead of time." BIO remains concerned that this language will create further beneficiary confusion. Patients may

interpret this language as a sign that they may receive surprise medical bills after participating in the MPPP or that their monthly bills will be irregular if they participate. As a result, patients may be less willing to enroll in the program. Although a Part D sponsor's projection of a patient's bill may vary from the actual bill, patients should feel empowered that they can use plan projections of a patient's monthly bills under the MPPP to spread out their financial obligations and plan for future months. Accordingly, the language in the Model Documents should reflect the resources available for enrollees to receive a projected breakdown of their monthly bill, including any potential calculator tools and/or other CMS or plan materials. Instead of the current language above, BIO proposes that the language instead be replaced with the following: "a projected breakdown of your monthly bills can be found at <insert link as appropriate>."

In addition, we encourage CMS to add the following language under "What Other Benefits Can I Utilize with my Medicare Part D Plan?" in order to remind enrollees of other important cost-savings that can be utilized.

BIO's proposed language is underlined below:

What Other Benefits Can I Utilize with my Medicare Part D Plan?
Starting 2024, Medicare Part D plans now offer the following:

- Removal of copays for recommended vaccines
    - CDC-recommended adult vaccines are now free for individuals with Medicare Part D.
- $35 monthly cap on covered insulin products
    - Cost-sharing for insulin products is limited to no more than $35 per month for people with Medicare Part D. No deductibles apply.
- Reduction in coinsurance
    - Individuals with Medicare Part D who reach the catastrophic phase of coverage will no longer have any out-of-pocket responsibility for covered drugs for the remainder of the year.

We also encourage CMS to add the following qualifier to the section under "Extra Help" so that individuals who may not have qualified for Extra Help in the past can be reminded that they now may qualify for the program, due to the expansion of eligibility of Extra Help under the IRA.

BIO's proposed language is underlined below:

Extra Help: A Medicare program that helps pay your Medicare drug costs if you have limited income and resources. Starting 2024, Extra Help has been expanded to provide more assistance to eligible individuals. Visit secure.ssa.gov/i1020/start to find out if you qualify and apply. You can also apply with your state's Medicaid office. Visit Medicare.gov/basics/costs/help/drug-costs to learn more.

Part D Sponsor Initial Notice for Failure to Make Payments under the Medicare Prescription Payment Plan

CMS' proposed Model Document includes the following description: "Like any other debt, you're required to pay the amount you owe." Enrollees may interpret this language incorrectly to infer that they may receive late fees similar to other debts owed. However, as CMS has

stated in guidance, enrollees will not be penalized with any late fees from missing payments under the MPPP. Accordingly, we believe that a qualifier should be added as follows:
While you won't receive any late fees like with some other debts, you are still required to pay the amount you owe.

Part D Sponsor Notice for Failure to Make Payments under Medicare Prescription Payment Plan - Notification of Termination of Participation in the Medicare Prescription Payment Plan

BIO remains concerned that the current Model Document does not mention the opportunity for beneficiaries to demonstrate good cause and to be reinstated into the MPPP if they pay back overdue amounts. It is critical that patients who fall behind on payments be given the opportunity to reenroll in the program after paying back overdue amounts. As it currently stands, beneficiaries may not be aware of their reinstatement rights. Beneficiaries may also not be aware of the need to proactively opt-in again if they have been terminated from the MPPP but are interested in enrolling in a subsequent year. Accordingly, BIO proposes the following language underlined below:

Can I use this payment option in the future?
After paying back the total amount owed, you may contact your plan sponsor to be reinstated into the MPPP in the current plan year. Your plan sponsor may ask you to provide information to demonstrate good cause for nonpayment, like an emergency or unexpected situation.

In addition, we encourage CMS to include a new section within the Model Document, which may be titled "Important Information About Your Reinstatement Rights" to include more detailed information regarding enrollee rights for reinstatement. For instance, it is important that enrollees are aware of their right to appeal a Part D sponsor's rejection of the good cause determination. CMS can also use this section to inform enrollees of their ability to be reinstated in a subsequent plan year.

Conclusion

BIO appreciates CMS' efforts to implement this payment option and looks forward to partnering with CMS to finalize operational details and drive patient access into the MPPP. Should you have any questions, please contact us at 202-962-9200.

Sincerely,

/s/

Crystal Kuntz
Vice President
Healthcare Policy and Research

/s/

Melody Calkins
Senior Manager
Healthcare Policy

April 29, 2024

Submitted Electronically via https://www.regulations.gov

The Honorable Chiquita Brooks-LaSure
Administrator
Centers for Medicare & Medicaid Services (CMS)
7500 Security Boulevard
Baltimore, MD 21244

RE: Medicare Advantage and Prescription Drug Programs: Part C and Part D Medicare Prescription Payment Plan Model Documents (CMS-10882)

Dear Administrator Brooks-LaSure,

We, the undersigned organizations, represent diverse patient, survivor, and caregiver populations impacted by cancer and other chronic and rare diseases. Thank you for the opportunity to provide feedback and recommendations on the Centers for Medicare & Medicaid Services' (CMS) Medicare Advantage and Prescription Drug Programs: Part C and Part D Medicare Prescription Payment Plan Model Documents.

For many patients living with chronic and rare diseases, such as cancer, lupus, and others, financial barriers that come with managing these diagnoses can be a stressor, especially while navigating the physical symptoms of a disease and treatment. The successful implementation of the Medicare Prescription Payment Plan (MP3) program is critical, and we appreciate that CMS continues to work on ensuring smooth, timely implementation of the MP3 for beneficiaries, their providers, and other stakeholders. The six model notices are instrumental in supporting successful implementation of MP3 as they will be disseminated to Part D enrollees eligible for or considering participation in the Program.

Findings from the Cancer Support Community (CSC) Cancer Experience Registry (CER) examining financial toxicity among people with metastatic cancer, with 95% confidence intervals, found that patients experiencing financial toxicity are 5 times more likely to have suboptimal medication adherence. Financial toxicity is a pressing issue for all patients, including those impacted by cancer, and is worsened by confusion within the enrollment process of the MP3 and other programs intended to decrease financial burdens on patients. The recommendations outlined below aim to increase understanding of and adherence to the enrollment process and continued participation, decreasing delays and financial barriers, and therefore maximizing the intended benefits for patients.

For many Medicare beneficiaries, the new flexibility will be among the most direct impacts of the Inflation Reduction Act (IRA). With successful implementation, cost smoothing, along with the new annual out-of-pocket (OOP) cap, will protect beneficiaries from high upfront costs while reducing the

OOP burden of prescription drug costs for Medicare-eligible populations. Our organizations commend CMS for the measures taken to incorporate feedback on these draft documents to maximize Medicare beneficiaries' understanding of this program to encourage understanding and enrollment for patients.

We look forward to working with CMS to incorporate this patient feedback and ensure that all Medicare beneficiaries likely to benefit from the program, and their caregivers, have the necessary information to make enrollment and participation decisions that are best for them. It is our shared goal to amplify and support patients throughout the policy implementation process to increase program participation and overall success. We are pleased to share comments and recommendations incorporating feedback directly from patients, survivors, and caregivers to improve clarity and understanding.

Document 1: Likely to Benefit Notice ("Consider Managing Your Monthly Drug Costs with the Medicare Prescription Payment Plan")

We recommend that this document be revised to include information on where to find the beneficiary's plan's website and phone number. In addition, we recommend providing hypothetical scenarios to clarify how monthly payments are calculated, based on feedback that the calculations to determine whether a beneficiary is likely to benefit are confusing and unclear. This recommendation is similar to what is currently provided in the Summary of Benefits and Coverage Template[1] used by the U.S. Department of Labor.

Lastly, if payments may change every month, we recommend that CMS develops an infrastructure or model to estimate increased costs on upcoming monthly bills to maximize beneficiary understanding, decrease financial toxicity, and reduce stress for patients caused by unknown OOP costs. To mitigate this issue, we propose collaborations with pharmacists to create a system that allows them to estimate the new upcoming monthly cost based on additional prescriptions at the point of sale (POS).

Document 2: Election Request Form ("Medicare Prescription Payment Plan participation request form")

Based on multiple patients' feedback, there is confusion on when participation takes effect. CMS could improve beneficiary understanding and participation in MP3 by establishing a consistent and mandatory time frame for plans to notify beneficiaries that their participation in the MP3 is active. CMS could further require that plans include participation information as part of the estimated response time for acceptance or denial on the election request form. Additionally, some patients are hesitant to ask for their full Medicare number due to fear of sensitive data leaks, inhibiting participation. We urge CMS to consider only requiring the last four digits of the Medicare number to address these concerns.

[1] https://www.dol.gov/sites/dolgov/files/EBSA/laws-and-regulations/laws/affordable-care-act/for-employers-and-advisers/sbc-template-new.pdf

Document 3: Notice of Election Approval ("Part D Sponsor Notice to Acknowledge Acceptance of Election to the Medicare Prescription Payment Plan")

The Notice of Election Approval lacks details beneficiaries may need to ensure compliance with MP3 requirements. We recommend CMS revise the document to clarify whether remaining balances after MP3 termination must be paid by the end of the year and explicitly state the grace period or timeline of payment reminders, including involuntary termination due to missed payments. This additional information will mitigate unexpected surprises and minimize confusion if beneficiaries understand in advance the parameters and expectations for payment.

Finally, as written, it is unclear if beneficiaries who remain in their Part D plan year after year retain participation in the MP3 automatically, unless terminated. If that is not the case, the document should make it clear that participants must opt in each year.

Document 4: Notice of Failure to Pay ("Part D Sponsor Notice for Failure to Make Payments under Medicare Prescription Payment Plan")

We appreciate that the Notice of Failure to Pay clearly informs beneficiaries that their enrollment in the Part D plan is not impacted by their failure to pay and that the document encourages plans to permit partial payments to enable participants to continue in the MP3.

However, we encourage CMS to outline how beneficiaries can pay by mail by providing the address and mailing instructions of the plan sponsor to provide as many payment options as possible. Additionally, our patients noted that several documents, including the Notice of Failure to Pay, led them to believe that they can make monthly payments for outstanding balances after voluntary termination without specifying an end date. CMS should clarify if the end date for payment of outstanding balances after voluntary termination is December of the plan year.

Document 5: Notice of Involuntary Termination ("Part D Sponsor Notice for Failure to Make Payments under Medicare Prescription Payment Plan – Notification of Termination of Participation in the Medicare Prescription Payment Plan")

We believe that this document may give beneficiaries the impression that plan sponsors can have different options for paying outstanding balances whereas other documents suggest that beneficiaries can continue to make monthly payments for outstanding balances after leaving the program or changing providers. To increase beneficiary understanding and successful participation in MP3, we recommend CMS reviews all MP3 documents to ensure consistency in wording. We recommend that CMS provides information explaining how to review plan policies and procedures. Lastly, we believe that the document could be improved by including the date that the 'Failure to Pay' notice was sent.

Document 6: Notice of Voluntary Termination ("Part D Sponsor Notification of Voluntary Removal from the Medicare Prescription Payment Plan")

We recommend that CMS outlines re-enrollment options for beneficiaries after their outstanding balance has been paid to promote continued participation and success of the Program. Additionally, we reiterate our previous recommendation to include information on how to pay by mail.

Additional Comments

We greatly appreciate the opportunity to review and provide comments on the MP3 documents. We support policies that improve affordability and help to lower costs for patients, with the goal of decreasing financial burdens and increasing access to lifesaving medications. To that end, MP3 documents outline the requirements of monthly payments, but do not specify a term limit or need for re-enrollment each year. We urge CMS to clarify the term limit for MP3 and also provide reenrollment information.

We thank you for the opportunity to comment on CMS' Part C and Part D Medicare Prescription Payment Plan Model Documents. We look forward to continuing to work together to ensure that all Medicare beneficiaries have access to the treatments they need without the financial barriers associated with high out-of-pocket costs.

If you have any questions, please contact Daneen Sekoni, MHSA at dsekoni@cancersupportcommunity.org or (202) 659-9707.

Sincerely,

Cancer Support Community
Association of Cancer Care Centers
Cancer*Care*
Cancer Fashionista Foundation
Caregiver Action Network
FORCE: Facing Our Risk of Cancer Empowerment
LUNGevity Foundation
Lupus and Allied Diseases Association, Inc.
Retire Safe
Triage Cancer
Triple Negative Breast Cancer Foundation

PUBLIC SUBMISSION

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Submission Type: API

Docket: CMS-2024-0093
The Medicare Advantage and Prescription Drug Programs: Part C and Part D Medicare Prescription Payment Plan Model Documents (CMS-10882)

Comment On: CMS-2024-0093-0001
The Medicare Advantage and Prescription Drug Programs: Part C and Part D Medicare Prescription Payment Plan Model Documents (CMS-10882)

Document: CMS-2024-0093-DRAFT-0010
Comment on CMS-2024-0093-0001

Submitter Information

Email: bethtodd@cap-rx.com
Organization: Capital Rx

General Comment

In regard to the Medicare Prescription Payment Plan Likely to Benefit Notice, how should this letter be utilized? It appears to be a model letter but has no address or header for mailing nor does it have a model id number. Should it be included with a companion piece?

In regard to the Medicare Prescription Payment Plan Participation Request Form, how much information is required to considered this form complete? Is there a minimum amount that would require the plan sponsor to call the member to obtain further information?

Also regarding the the Medicare Prescription Payment Plan Participation Request Form , what should the plan sponsor do with the OHI information received in response to this question - Do you get help paying your prescription drug costs from a program like Medicare’s Extra Help, a State Pharmaceutical Assistance Program (SPAP), Indian Health Services, or other health insurance?

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Washington, D.C., 20004

Submitted electronically via www.regulations.gov

April 26, 2024

The Honorable William N. Parham, III
Centers for Medicare & Medicaid Services
Director, Paperwork Reduction Staff
Office of Strategic Operations and Regulatory Affairs
Division of Regulations Development
Attention: Document Identifier/OMB Control Number: Room C4-26-05
7500 Security Boulevard
Baltimore, MD 21244-1850

Re: The Medicare Advantage and Prescription Drug Programs: Part C and Part D Medicare Prescription Payment Plan Model Documents (CMS-10882)

Dear Director Parham:

Thank you for the opportunity to comment on the Centers for Medicare & Medicaid Services' (CMS) Medicare Prescription Payment Plan (Program) Model Documents (Model Documents)[1], issued for comment pursuant to a Paperwork Reduction Act Notice published by CMS in the Federal Register on February 29, 2024.[2]

CVS Health serves millions of people through our local presence, digital channels, and our nearly 300,000 dedicated colleagues – including more than 40,000 physicians, pharmacists, nurses, and nurse practitioners. Aetna, a CVS Health company offers Medicare Advantage Prescription Drug (MA-PD) plans in 46 states and D.C. Aetna also offers robust standalone prescription drug plans (PDPs) to individuals in all 50 states and D.C. Our unique healthcare model gives us an unparalleled insight into how health systems may be improved to help consumers navigate the healthcare system–as well as their personal healthcare–by eliminating disparities, improving access, lowering costs, and being a trusted partner for every meaningful moment of health. And we do it all with heart every day.

We appreciate CMS providing model documents for the Program as this will streamline processes and ensure consistency, resulting in the smoother implementation of the Program. We support the provision of clear, plain language communications that are easy for beneficiaries to understand and are limited to the information necessary to effectuate the communication in issue. Shorter communications are more likely to be read by beneficiaries, and so wherever possible, communications should be limited to what

[1] The Model Documents are available at https://www.cms.gov/medicare/regulations-guidance/legislation/paperwork-reduction-act-1995/pra-listing/cms-10882
[2] See 89 Fed. Reg. at 14847 (February 29, 2024).

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is strictly necessary, with the links being provided so that beneficiaries can obtain more information if they wish.

We have included our comments on specific model documents in the attached Appendix.

Thank you for considering our comments. We welcome any follow-up questions you may have.

Sincerely,

Melissa Schulman
Senior Vice President
Government & Public Affairs
CVS Health

1275 Pennsylvania Ave NW, Suite 700
Washington, D.C., 20004

Appendix
Specific Comments on the Medicare Advantage and Prescription Drug Programs: Part C and Part D Medicare Prescription Payment Plan Model Documents

1. **Likely to Benefit Notice**

CVS Health requests CMS to consider adding language to explain the Program covers only Part D drugs. This is important for members in Employer Group Waiver Plans (EGWPs) or Enhanced Alternative Plans. These members may become confused and dissatisfied if their point of sale (POS charge is zero ($0) for covered Part D drugs, and the full patient cost share for non-Part D medications. This will lead to beneficiary questions that pharmacy staff may not be able to address, especially when a member obtains a combination of non-Part D medications (including Part B medications), and covered Part D medications at the same time.

So that members fully understand non-Part D medications are not covered by the Program, CVS Health recommends that CMS include language in the Evidence of Coverage (EOC) model communications and CMS-developed educational materials to clearly explain the Program applies only to Medicare Part D drugs.

CMS should include this language in the "Participating in this payment option is voluntary?" section of the Likely to Benefit Notice so that members can make appropriate elections into the payment plan.

CVS Health also recommends changes to the notice to provide beneficiaries more clarity around the Program and remove some redundant language. Examples are as follows:

- **Specify "plan benefit year" versus January -December**
- **Repositioned the information on the 2025 out-of-pocket costs near the top of the document**
- **Added language to specify "qualified" drugs**
- **Removed language that was seemed redundant**

In Exhibit A attached to these comments, we have included an updated "Likely to Benefit Notice" for CMS to consider.

In addition, as stated in our comments to the Draft Part Two Program guidance, we ask CMS to condense the Likely to Benefit Notice to a single page. We believe this can be done by changing the font and format of the document and removing redundant language. However, if the CMS determines the general Likely to Benefit Notice cannot be reduced to a single page, we ask CMS to produce a specific Likely to Benefit Notice for the pharmacies that is limited to a single page. Many pharmacy systems with automated printing capabilities are restricted to printing a single page document, similar to the Know Your Rights model notice. This notice should be limited to, easy- to-read information that directs members to their plan or plan website for additional information on the Program, and not include information pharmacy staff may not be able to address.

Recommendations:

- **CMS should include language explaining the Program applies only to covered Part D drugs. This will alleviate potential member confusion and abrasion, reducing CTMs and/or grievances, for enrollees in EGWPs or Enhanced Alternative Plans.**
- **This language should also be included in the CMS-developed materials and the "Likely to Benefit Notice".**
- **CMS should consider changes to the Notice to improve clarity and streamline the language, as shown in the revised notice in Exhibit A.**

- **CMS should limit the Likely to Benefit Notice pharmacies must provide to a single page to conform with automated POS printing capabilities, with easy-to-read information that directs members to their plan or its website for additional information on the Program.**

2. Election Request Form

CVS Health recommends that CMS add a signature line for Authorized Representative with a statement such as: "If you're the authorized representative, sign and fill out these fields."

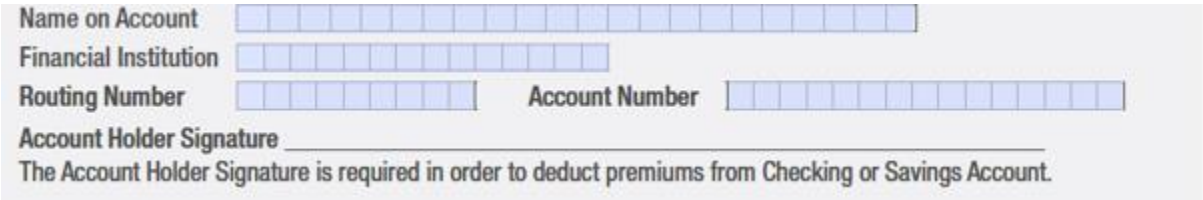
We recommend that CMS add a billing payment section, similar to the plan Enrollment Form, Exhibit 1, to the model Election Request Form. This will help streamline the opt-in process for enrollees as well as the Part D sponsor. Not including the basic payment information for enrollees at the time of opt-in, would require additional enrollee contact to obtain the information later, and additional administrative action by the plan. Having a section for the payment information would make the opt-in process more seamless.

The payment section could include the following information and fields:

"Paying your Medicare Payment Plan Billing Amounts"

"You can pay your monthly billing amounts by mail, electronic funds transfer (EFT) which is an automatic withdrawal from your bank account."

The form should provide appropriate space for the enrollee to include the name of the account, financial institution information, bank routing number, and account number, as well as the day they prefer the amount to be withdrawn. Below is a sample mock-up.



This section would advise enrollees that they may use their credit or debit card and to call the appropriate customer service telephone number, as this information is precluded from displaying on the form.

Finally, we ask that CMS include variable fields in the billing section for flexibility to include plan-specific information.

Recommendations:

- **CMS should add a signature line for an Authorized Representative.**
- **CMS should add a billing payment section to the Election Request Form to improve member experience and minimize the need for further outreach to obtain this information.**

3. Notice of Election Approval

CVS Health recommends splitting the two paragraphs under the section titled, "Can I Leave the Medicare Prescription Payment Plan?" The second paragraph describing changing plan benefit should have a separate title to differentiate and clarify the two different processes for enrollees. The paragraph

would read as follows:

> **"What if I Change Medicare Plans?"**
> "If you leave <current plan name> or change to a new Medicare drug plan or Medicare health plan with drug coverage (like a Medicare Advantage Plan) your participation in the Medicare Prescription Payment Plan will end. If you change plans, and you'd like to join the Medicare Prescription Payment Plan offered through your new plan, contact your new plan."

Recommendations:

- **CVS Health recommends adding a new header before the second paragraph in the "Can I Leave the Medicare Prescription Payment Plan?" section to differentiate the information regarding change to a different Medicare Plan from the preceding information regarding leaving the payment plan.**

4. Request for Information (RFI) Notice

The final Part One guidance requires Part D sponsors to contact the member to request additional information from the enrollee if the election request form is incomplete. We ask that CMS provide a model form for this purpose. The requested model could also serve to acknowledge Plan receipt of the election request form and to inform enrollees their request will be processed and they will receive a notice confirming successful opt-in once the missing information is received. CVS Health requests that this template contains variable language to accommodate various scenarios, including:

- Missing signature.
- Not the member or legal representative
- Past due payment plan amount balance.
- Plan enrollment not yet accepted or pending.

Recommendations:

- **CVS Health asks CMS to provide a model "Request for Information" form.**

5. Request for Billing Invoice Template

CVS Health asks CMS to provide a billing invoice template to ensure that all required elements are included. A model with the required elements would contribute towards greater consistency and standardization in stand the marketplace and minimize enrollee confusion.

Recommendation:

- **CVS Health asks CMS to create a Billing Invoice template for the payment plan.**

6. Notice of Denial

Per the Final Part One Guidance, a "written" notice is required to be sent to the enrollee that explains the reason for the denial in the Program, such as failure to provide missing information to complete the Election Request Form within the required 21-day timeframe. CVS Health asks CMS to create a model Notice of Denial to communicate the required information to enrollees.

Recommendations:

- **CVS Health requests that CMS develop a model Notice of Denial that includes the required elements to communicate to the enrollee, as appropriate.**

7. Initial Notice of Failure to Pay

CVS Health recommends that CMS add clarifying language related to plan premiums in the section "What if I can't afford to pay both my plan premium and my Medicare Prescription Payment Plan payment?" This would further help differentiate the plan premium from the Program billing for enrollees as well as Program payment options. The language would read as follows:

> "Always pay your <plan name> **Prescription Drug Plan (PDP)** premium first (if you have one). If you recently paid your monthly Medicare Prescription Payment Plan instead of your Health and Drug coverage, call us at <phone number> to discuss moving the payment."

Recommendations:

- **CVS Health requests clarification to the "What if I can't afford to pay both my plan premium and my Medicare Prescription Payment Plan payment?" section of this notice to clarify instructions for enrollees.**

8. Notice of Involuntary Termination

In its Supporting Statement, CMS states the Notice of Involuntary Termination includes language regarding the reinstatement process and clarifies that a member still owes the overdue amount and describes the process for paying the outstanding balance. However, the model Notice of Involuntary Termination does not include any language regarding reinstatement. Therefore, we ask CMS to create a model form for this purpose that would be sent to enrollees upon successful payment of amounts due and/or positive "good cause" criteria review.

We also request that CMS align the varying titles of the termination of participation notice in the guidance as well as the title of the model itself. This will provide consistency in the naming conventions or references to models to ensure the correct model is provided to enrollees at the appropriate times. For example, the Supporting Statement refers to this model document as "Notice of Involuntary Termination" however; the actual model title in the document is the "Notice for Failure to Make Payments under Medicare Prescription Payment Plan," and the file name in the PRA package refers to this notice as "Removal for Failure to Pay."

Finally, CVS Health requests that CMS confirm a Transaction Reply Code (TRC) will be sent to plan sponsors upon voluntary and involuntary removal from the Program when the plan sponsors submit the "opt-out" on the Transaction Code (TC) to CMS.

Recommendations:

- **CVS Health requests a new model "Notice of Reinstatement in the Payment Plan."**
- **CVS Health requests consistent naming conventions for "The Notice of Involuntary Termination."**
- **CVS Health requests CMS provide technical guidelines for TRCs and TCs in relation to enrollee removal from and/or reinstatement in the payment plan.**

9. Notice of Voluntary Termination

CVS Health recommends that in the "How Do I Pay My Balance?" section, CMS remove the unpaid amounts section shown and instead refers enrollees to the monthly invoices and the instruction to call the plan. This would simplify the notice for enrollees and provides timely billing information. The recommended verbiage would read as follows:

> "If you have questions about your payment or unpaid balance, call us at <phone number>, <days and hours of operation>. TTY users can call <TTY number>."

Recommendations:

- **CVS Health requests removal of the unpaid amount in the "How Do I Pay My Balance" section.**

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Exhibit A

CVS Health suggested revisions to the "Likely to Benefit Notice"

Consider Managing Your Monthly Drug Costs with the Medicare Prescription Payment Plan
You might benefit from participating in the Medicare Prescription Payment Plan, because you have high drug costs. This new payment option works with your current drug coverage, and it can help you manage your drug costs by spreading them across **monthly payments that vary throughout the plan benefit year.**

What's the Medicare Prescription Payment Plan?
The Medicare Prescription Payment Plan is a new payment option to help you manage your out-of-pocket drug costs, starting in 2025. If you select this payment option, each month you'll pay your plan premium (if you have one) and you'll get a bill from your health or drug plan for your prescription drugs (instead of paying the pharmacy).

Participating in this payment option is voluntary. Anyone with a Medicare drug plan or a Medicare health plan with drug coverage can use this payment option, which applies to prescription drugs covered by Part D. This program does not apply to Part B or non-Part D prescription drugs.

How will my costs work with this payment option?
The new prescription drug law caps your out-of-pocket costs at $2,000 in 2025 and eliminates the coverage gap (known as the "donut hole"). This means you'll never pay more than $2,000 in out-of-pocket drug costs in 2025.

When you fill a prescription for a drug covered by Part D, you won't pay your pharmacy directly. Instead, you'll get a bill each month from your plan. Your monthly bill is based on what you owe for any qualifying prescriptions you get, plus your previous month's balance, divided by the number of months left in the plan benefit year.

Note: Your payments might change every month, so you might not know what your exact bill will be ahead of time. Future payments might increase when you fill a qualified new prescription or refill an existing prescription because as new out-of-pocket drug costs are added into your monthly payment, there are fewer months left in the year to spread out your payments.
How do I know if this payment option might not be right for me?
This payment option might not be helpful for you if:

- You get Extra Help from Medicare.
- You qualify for a Medicare Savings Program.
- You get help paying for your drugs from other organizations, like a State Pharmaceutical Assistance Program (SPAP) or other health coverage.
- Your yearly drug costs are low.

- Your drug costs are the same each month.
- You're considering signing up for the payment option late in the calendar year (after September).
- You don't want to change how you pay for your drugs.

Who can help me decide if I should sign up for this payment option?

- **Your plan:** Visit your plan's website, or call your plan to get more information. Your plan's phone number is on the back of your membership card.
- **Medicare:** Visit Medicare.gov/tbd, or call 1-800-MEDICARE (1-800- 633-4227), 24 hours a day, 7 days a week. TTY users can call 1-877-486-2048.
- **State Health Insurance Program (SHIP):** Visit shiphelp.org to get the phone number for your local SHIP and get free, personalized health insurance counseling.

How do I sign up for this payment option?

To sign up for this payment option, visit your plan's website or call your plan. You can find your plan's phone number on the back of your membership card. If you need to pick up a prescription urgently, the fastest way to use this payment option is to call your plan.

Need this information in another format or language?

To get this material in other formats like large print, braille, or another language, contact your Medicare drug plan. If you need help contacting your plan, call: 1-800-MEDICARE (1-800-633-4227.

April 26, 2024

VIA ELECTRONIC DELIVERY – www.regulations.gov

Lilly USA, LLC

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William N. Parham, III
Director, Division of Information Collections and Regulatory Impacts
Office of Strategic Operations and Regulatory Affairs
Centers for Medicare & Medicaid Services
7500 Security Boulevard
Baltimore, Maryland 21244
Attention: Medicare Prescription Payment Plan (CMS-10882)

RE: The Medicare Advantage and Prescription Drug Programs: Part C and Part D Medicare Prescription Payment Plan Model Documents

Dear Mr. Parham,

Eli Lilly and Company (Lilly) is pleased to respond to the information request on the Medicare Advantage and Prescription Drug Programs: Part C and Part D Medicare Prescription Payment Plan Model (MPPP) Documents.[1] Lilly is one of the country's leading innovation-driven, research-based pharmaceutical and biotechnology corporations. Our company is devoted to seeking answers for some of the world's most urgent medical needs through discovery and development of breakthrough medicines and technologies and through the health information we offer. Ultimately, our goal is to develop products that save and improve patients' lives. Lilly thanks CMS for its guidance and willingness to prioritize MPPP outreach and education. We are supportive of widespread educational efforts on the MPPP and applaud CMS for its efforts in making the MPPP available for all Part D enrollees in 2025.

As a member of both the Pharmaceutical Researchers and Manufacturers Association of America (PhRMA) and the Biotechnology Industry Organization (BIO), Lilly largely joins those groups in their comments and encourages CMS to carefully consider the input of those organizations. That said, Lilly would like to offer the following comments.

I. CMS Should Implement a Comprehensive Outreach and Education Plan for All Standard Beneficiaries on All Part D Plan Benefit Changes

Lilly applauds CMS dedication to outreach and education to patients on the MPPP program. This education should also encompass the new $2,000 maximum out-of-pocket cap and the removal of the coverage gap in the Part D design. In addition, CMS should remind patients of the changes that have already occurred as a result of the IRA (e.g., $35 copay for covered insulins, changes to the Extra Help Program, etc.). Kaiser Family Foundations conducted a poll in July 2023 showing that awareness of these newly introduced prescription drug provisions is low, even among adults 65 and older.[2] CMS leading the charge on ensuring that patients understand the major provisions of the Part D redesign resulting from the IRA will go a long way in guaranteeing a smooth transition for all interested parties.

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[1] 89 Fed. Reg. 14847-48 (Feb. 29, 2024).
[2] KFF Health Tracking Poll July 2023: The Public's Views Of New Prescription Weight Loss Drugs And Prescription Drug Costs. August 4, 2023. Available: https://www.kff.org/health-costs/poll-finding/kff-health-tracking-poll-july-2023-the-publics-views-of-new-prescription-weight-loss-drugs-and-prescription-drug-costs/.

Per CMS' guidance, the Part D redesign will assist patients with access and affordability of prescription medications by changing stakeholder financial responsibilities resulting in maximum patient OOPs and the removal of the coverage gap. The MPPP, a component of the redesign, aims to assist patients in handling monthly expenses. Certain elements of the program might pose challenges, particularly due to intricate calculations and enrollment choices. Considering the complexity of the program, effective educational efforts by CMS, along with other stakeholders, are crucial for preparing patients for program changes and successfully enrolling Part D beneficiaries into the MPPP. Exclusively relying on plans for patient communication may exacerbate communication gaps and foster confusion, as evidenced during the early days of ACA enrollment when many consumers struggled to decipher new provider directories and understand Qualified Health Plan (QHP) terminology.[3]

In addition to the MPPP Model Documents, Lilly recommends CMS develop and launch a campaign for all Medicare beneficiaries and other significant stakeholders (e.g., caregivers, pharmacists, prescribers, and counselors educating beneficiaries) inclusive of important plan benefit design changes in their entirety. This effort should be independent of the traditional annual beneficiary education and outreach activities related to open enrollment season, to ensure that all patients are aware of the potential benefits available to them. CMS implemented such a campaign with great success in 2005 ahead of the launch of Part D.

Information dissemination should utilize multiple touchpoints such as social media, traditional media outlets, community events, and educational workshops to reach a wide audience spectrum.[4] CMS should include Medicare.gov, the "Medicare and You" handbook, customer service representative engagement at 1-800-MEDICARE, and interactive tools on Plan Finder in their rollout. Additionally, CMS should employ multiple deliverers of the message, including CMS regional offices, experts and community leaders. Moreover, creating easy-to-read materials with clear language, visual aids, and simplified explanations ensures complex concepts are easily understood for all audiences.[5]

II. CMS Should Revisit the Proposed Model Documents and Revise to Ensure Understandability for Patients and Caregivers and Guarantee Clarity Regarding MPPP and Other Components of the IRA

While the proposed model documents are informative, their readability should be revisited and revised to ensure they are accessible and understandable for patients and caregivers. This starts with the 'MPPP Likely to Benefit' template. This document sets the tone for the suite of templates and should be amended to remind patients of the affordability changes that have been implemented due to the IRA and inform patients of the changes that will begin in 2025. For example, in the 'MPPP Likely to Benefit' template, a paragraph could be added before the current introductory paragraph that reminds patients of the $35 copay for covered insulins, the changes to the Extra Help program, and the changes with patient financial responsibility for certain vaccines. Once that is done, the current first paragraph could be rewritten as follows:

---

[3] 2016 Report on PPACA and Enrollee Satisfaction: GAO-16-761, PATIENT PROTECTION AND AFFORDABLE CARE ACT: Most Enrollees Reported Satisfaction with Their Health Plans, Although Some Concerns Exist

[4] "Strategies for Effective Communication: A Handbook for Communicators," World Health Organization, 2019.

[5] "Plain Language: Improving Communication from the Federal Government to the Public," Center for Plain Language, 2020.

> *'In 2025, your maximum out of pocket expenditure for covered prescription medications will be $2,000 and the coverage gap (i.e., the 'donut hole') will no longer exist. In addition to these changes, you might benefit from participating in the Medicare Prescription Payment Plan. If you opt in, this plan may help you manage your monthly expenses by spreading out your prescription drug costs over your plan year (i.e., January – December). Our records show that you have high prescription drug costs that you are paying when your prescriptions are filled. Under the Medicare Prescription Payment Plan, you will pay nothing at the pharmacy counter and will be billed monthly by your coverage provider after your prescription has been filled. The payment might vary from month to month, depending on when and how often you fill your covered prescriptions, but you will pay no more than $2,000 for all covered medications in 2025!'*

The rest of the document should be altered so that it has the same voice throughout. Similarly, all model documents should then be updated to ensure they are equally informative and maintain a consistent tone for the patient/caregiver. There have been several changes to Medicare Part D over recent years that can have significant impact to its beneficiaries. Ensuring that patients and their caregivers are informed so that they can make the best decisions possible for their medical care is crucial.

***

Lilly is grateful for the opportunity to comment on the MPPP Model Documents. We sincerely appreciate your thoughtful consideration of the issues discussed in this letter and look forward to working with you in the future to help ensure that patients have meaningful access to affordable health care benefits and prescription drug coverage. Please do not hesitate to contact Derek Asay at Asay_Derek_L@Lilly.com with any questions.

Sincerely,

Derek L. Asay
Senior Vice President,
Government Strategy and Federal Accounts

Shawn O'Neail
Senior Vice President,
Global Government Affairs

Exhibit 4 - Part D Sponsor Notification of Voluntary Removal from the Medicare Prescription Payment Plan

Referenced in [insert draft part 2 guidance section]

<Part D sponsors may insert a title for the notice, such as "You're no longer participating in the Medicare Prescription Payment Plan through <plan sponsor>">

<Member #>

<RxID>

<RxGroup>

<RxBin>

<RxPCN>

Dear <Member>,

Starting <insert effective date>, you're no longer participating in the Medicare Prescription Payment Plan through <plan sponsor>. As of <effective date>, you'll pay the pharmacy directly for your out-of-pocket drug costs.

You're getting this letter because you either asked to stop participating in this payment option, **or** you changed your Medicare drug plan or Medicare health plan with drug coverage (like a Medicare Advantage Plan). If you changed plans, and you'd like to join the Medicare Prescription Payment Plan offered through your new plan, contact your new plan.

This letter only applies to your participation in the Medicare Prescription Payment Plan. Your Medicare drug coverage and other Medicare benefits won't be affected, and you'll continue to be enrolled in <plan name> for your drug coverage.

How do I pay my balance?

You can choose to pay the amount you owe all at once or be billed monthly. You'll never pay any interest or fees on the amount you owe, even if your payment is late.

You owe <insert unpaid>. You can pay:

- Online at <plan's website>, by credit or debit card.
- Through the mail, by check.
- <insert other payment methods offered by the plan sponsor like electronic funds transfer (including automatic charges of an account at a financial institution or credit or debit card account)>.

If you have questions about your payment, call us at <phone number>, <days and hours of operation>. TTY users can call <TTY number>.

What happens if I don't pay my balance?

Like any other debt, you're required to pay the amount you owe. As long as you continue to pay your plan premium (if you have one), you'll still have drug coverage.

Can I use this payment option in the future?

- **If you're still in <plan name>:** Yes. Visit <insert PDP webpage where the application is>, or call us at <phone number> <days and hours of operation>. TTY users can call <TTY number>.
- **If you're joining a new plan:** Yes. All Medicare drug plans and Medicare health plans with drug coverage must offer this payment option. No matter what Medicare drug plan you're in, you can choose to rejoin the Medicare Prescription Payment Plan at any time.

Are there programs that can help lower my costs?

You may be eligible for programs that can help lower your costs, like:

- **Extra Help:** A Medicare program that helps pay your Medicare drug costs if you have limited income and resources. Visit secure.ssa.gov/i1020/start to find out if you qualify and apply. You can also apply with your state's Medicaid office. Visit Medicare.gov/basics/costs/help/drug-costs to learn more.
- **Medicare Savings Program**: A state-run program that helps people with limited income and resources pay some or all of their Medicare premiums, deductibles, and coinsurance. Visit Medicare.gov/medicare-savings-programs to learn more.
- **State Pharmaceutical Assistance Program (SPAP):** A program that may include coverage for your Medicare drug plan premiums and/or cost sharing. SPAP contributions may count toward your Medicare drug coverage out-of-pocket limit. Visit go.medicare.gov/spap to learn more.
- **Manufacturer's Pharmaceutical Assistance Programs** (sometimes called Patient Assistance Programs (PAPs)): A program from drug manufacturers to help lower drugs costs for people with Medicare. Visit go.medicare.gov/pap to learn more.

Many people qualify for savings and don't realize it. Visit Medicare.gov/basics/costs/help, or contact your local Social Security office to learn more. Find your local Social Security office at secure.ssa.gov/ICON/main.jsp or call 1-800-772-1213. TTY users can call 1-800-325-0778.

Note: The programs listed above can help lower your costs, but they can't help you pay off your Medicare Prescription Payment Plan balance.

www.HaystackProject.org

By Electronic Transmission through regulations.gov

April 29, 2024

The Honorable Chiquita Brooks-LaSure
Administrator
Centers for Medicare & Medicaid Services
Department of Health and Human Services
P.O. Box 8013
Baltimore, MD 21244–1850

RE: The Medicare Advantage and Prescription Drug Programs: Part C and Part D Medicare Prescription Payment Plan Model Documents (CMS-10882)

Dear Administrator Brooks-LaSure:

Haystack Project is pleased to contribute feedback and recommendations on the six model documents the Centers for Medicare & Medicaid Services (CMS) released as part of its implementation of the Medicare Prescription Payment Plan (MPPP).

Haystack Project is a 501(c)(3) non-profit organization enabling rare and ultra-rare disease advocacy organizations to highlight and address systemic access barriers to the therapies they desperately need. We strive to amplify the patient and caregiver voice in disease states where unmet need is high, and treatment delays, denials and inadequacies can be catastrophic. Our core mission is to evolve health care payment and delivery systems, spurring innovation and quality in care toward effective, accessible treatment options for Americans living with rare or ultra-rare conditions. Haystack Project is committed to educating policymakers and other stakeholders about the unique circumstances of extremely rare conditions with respect to product development and fair access to care.

Medications for rare and ultra-rare conditions tend to be placed on the highest tiers of Part D

plan formularies. Since most rare and ultra-rare patients lack an FDA-approved, disease-specific treatment, our patients must rely on off-label treatments and often require multiple medications to manage disease symptoms and/or slow disease progression. Patients have frequently found that the cost of filling their prescriptions, particularly at the beginning of the plan year, is too high to be absorbed within a single month. The MPPP, therefore, offers tangible relief from the financial burdens associated with high or unexpected out-of-pocket costs for our patient communities relying on Medicare Part D to access medications,

In Haystack Project's comments to CMS' MPPP Part Two Guidance, we emphasized the critical role effective beneficiary outreach and education will play in facilitating the MPPP's success. We fully supported CMS' proposal to create model notices, forms, and beneficiary communications and urged the Agency to release these resources in draft form so that patients and advocacy organizations have an opportunity to offer feedback and input. We applaud CMS for not only soliciting feedback on the six model documents but providing sufficient time for Haystack Project to collect input from actual patients and caregivers.

We distributed the six model documents to our member organizations, asking that they reach out to patients and caregivers within their communities with the inquiry below:

> Tell us YOUR FIRST IMPRESSIONS (as if you'd just received them in the mail) -- what makes sense in each one, and what doesn't?
> - What do you think each document is telling you?
> - What questions does each leave you wanting to ask?
>
> Even if you understood it, would you have said something differently? If you didn't understand it, that's very helpful too!

Our comments reflect input gathered from patients, caregivers, and our patient advocacy organization members, including initial impressions as well as any questions or confusion on the MPPP and "next steps" patients receiving the document should take.

General Feedback on the MPPP and Model Documents

Haystack Project's patients were generally enthusiastic about the MPPP as it offers an opportunity to help beneficiaries ineligible for other forms of assistance to afford their life saving prescriptions. By spreading out-of-pocket (OOP) costs evenly over the course of a year, many Medicare beneficiaries can minimize the possibility that they will have to choose between receiving their medication and paying their housing, utility, and transportation bills.

Patients reviewing the model documents appreciated that CMS reiterated that there are a variety of ways to pay MPPP bills, that not participating in the MPPP would have no impact on Medicare Coverage or their Part D plan, and that other programs exist that might reduce OOP costs for eligible patients. They conveyed that this information, included throughout the series of documents, was clear and helpful.

Much of the feedback centered on information ***not*** provided in the model documents. For example, CMS has not outlined its plan to adapt the content of the model documents to meet the needs of non-English speaking beneficiaries and those with disabilities. Haystack Project's member community includes patients with progressive conditions impacting both vision and hearing as well as families with limited proficiency reading technical information presented in English. We urge the Agency to consider developing a set of informational videos with guidance in several languages, including American Sign Language (ASE) and to provide the model documents in Braille, large print, and in formats compatible with screen readers and other accessibility tools.

In addition, neither the model documents nor CMS' Guidance to date provides any clarity on whether and how a plan could decline to accept an individual's request to participate in the MPPP during the initial program year. Since the IRA requires that plans make the Program available to all enrollees and does not provide for any denial mechanism other than involuntary termination in the previous year, initial year acceptance of participation requests appears to be a ministerial task, rather than a determination requiring review and a decision. We once again urge CMS to create a real-time opt-in mechanism. This could be as simple as enabling participants to present their opt-in confirmation number as evidence of MPPP participation when picking up their prescription. We believe this would reduce the need for retroactive participation and ensure that individuals unable to pay at the pharmacy counter and wait for a "refund" do not walk away without necessary medication. This issue is critically important to Haystack Project and its patient communities and appropriate resolution could eliminate patient frustration with the MPPP that could carry over into subsequent years.

Finally, patients and caregivers reviewing the documents were unable to determine whether participants have to submit an election request every year, only when they have switched plans, or just once (with participation continuing until terminated). We strongly encourage CMS to mandate that plans maintain their enrollees' participation from one year to the next if they are currently auto-enrolling beneficiaries into their plans. Participants would then be reminded that they have the option to opt out of participation at any time. This approach would streamline the process for Medicare beneficiaries who might otherwise assume that both their

plan enrollment and program participation automatically continue from year to year. Information on whether and when a new election request must be submitted should be included in Documents 1-3.

Document 1: Likely to Benefit Notice ("Consider Managing Your Monthly Drug Costs with the Medicare Prescription Payment Plan")

Haystack Project understands that individuals encountering high OOP costs later in the plan year may be less likely to benefit from MPPP participation. These patients may, however, benefit from receiving MPPP information when they encounter high OOP costs so they can consider opting in for the next plan year. We urge CMS to ensure that when patients meet cost thresholds meeting the "likely to benefit" criteria in the fourth quarter, plans give these individuals an opportunity to opt in for either/both the current and next plan year.

With respect to the Likely to Benefit Notice, patients noted that it was packed with information, yet did not clearly convey the potential benefits of participation. Individuals suggested presenting information in bullet-point format and providing example calculations so that Medicare beneficiaries have a better understanding of how the MPPP works.

In addition, individuals reviewing the documents expressed both concerns and questions, including:

- Will individuals receive more than one bill per month from their plan?

- Ultra-rare disease patients might "shy away" from "any complications and insurance company fights when I first hear about the program. I would be concerned (just from the info in Document #1) that there might be confusion with the pharmacy/mail order provider about giving me the medication without payment at point of service."

- The information on Document #3 explaining that pharmacies will be notified should be included in Document 1, and there should be clear information on what a patient can and should do if a pharmacy asks for payment at the pharmacy counter.

- Document 1 looks like it was written by a lawyer and not someone who understands how people read documents. Breaking it up into sections/sidebars/text boxes may help make it more understandable as would a hypothetical and a separate

"frequently asked questions" document that could accompany each of the six model documents.

- The use of the term "payment option" was a bit confusing and CMS and Part D plans should refer to it at the beginning of Document 1 as an "optional payment plan" called the "Medicare Prescription Payment Plan."

- There was also confusion on whether the MPPP would bill participants based on the OOP maximum of $2000. A patient specifically asked, "will a participant be responsible for paying $2000 even if they don't have a prescription cost that adds up to $2000?"

- Although Document 1 includes the statement "[y]ou'll never pay any interest or fees on the amount you owe, even if your payment is late," it should also notify potential participants that individuals failing to make payments would not be eligible to participate in the MPPP with their existing plan until overdue payments are paid.

- Document 1 should also let individuals know that they can voluntarily exit the MPPP and go back to paying at the pharmacy counter.

- Although it was helpful to outline a set of scenarios that might make the MPPP less helpful for potential participants, including the example of patients with consistent monthly drug costs over the plan year might discourage individuals with extremely high, but even OOP costs throughout the year. CMS should clarify this example to ensure that, for example, individuals with predictable monthly costs of $1000 each month do not conclude that they would not benefit from MPPP participation.

Document 2: Election Request Form ("Medicare Prescription Payment Plan participation request form")

Although patients and caregivers within Haystack Project's communities generally found the Election Request Form easy to understand, we received feedback that::

- Participants need to know when their participation will take effect and when/how their plan will notify them that their request was received, processed, and approved.

- There does not appear to be enough space in the form for individuals with long last names.

- The terms and conditions should be consistent across plans and individuals should be able to read that information and agree to it when they submit their opt-in request. It will be difficult for patients to opt in if they have extra steps that need to be completed later and do not know how they will be informed of what to do and when.

- The Election Form should include information on other ways to opt in to the MPPP and let potential participants decide what opt in mechanism they are most comfortable with.

- It is unclear what types of communications might be made to the participant's phone. If, for example, plans wish to communicate by text message, the form should enable individuals to specify whether the number provided is a mobile number of landline.

Document 3: Notice of Election Approval ("Part D Sponsor Notice to Acknowledge Acceptance of Election to the Medicare Prescription Payment Plan")

As mentioned above, Document 3 contains information on voluntary termination and impact of failure to make payments under the MPPP that would be helpful to Medicare beneficiaries as they determine whether to participate in the MPPP. Although most individuals found the notice to be understandable and clear, others conveyed that they remained somewhat confused and uncertain of what next steps an individual should take after receiving this notice. Feedback included:

- Uncertainty on what a participant can/should do if their pharmacy requires that they pay at the pharmacy counter before taking their medication home.

- As in Document 1, patients would appreciate having an example in Document 3 illustrating how each monthly payment is calculated and what if any impact OOP costs paid prior to participation would have on calculations of monthly maximum payment. This would be especially important for individuals who, for example, paid

$1,000 or more in the first month of the plan year but had not received their MPPP participation approval until the second (or subsequent) month.

- Several individuals voiced confusion over whether ALL pharmacies within their plan would know that they participate in the MPPP or only those that had previously filled a prescription for the patient. Is there a mechanism needed to make the information more broadly available so that if, for example, a particular drug out of stock at the individual's usual pharmacy, they can go to any pharmacy carrying the medication without worrying that they will be asked to pay at the pharmacy.

- Although patients appreciate the ability to terminate their participation in the MPPP at any time, it would be helpful to require that plans give voluntary termination options in addition to communicating by telephone. In addition, patients are concerned that they will not know that their termination request was processed.

Document 4: Notice of Failure to Pay ("Part D Sponsor Notice for Failure to Make Payments under Medicare Prescription Payment Plan")

Haystack Project's patient community was pleased that CMS reiterated in the Notice of Failure to Pay that Part D enrollment is not connected to or impacted by the MPPP. Patients and caregivers appreciated that individuals falling behind on their MPPP payments might have the option of spreading their past-due amounts over the remainder of the year or making a partial payment. In addition, patients and caregivers:

- Expressed that it is "so nice to have optional programs spelled out on where to get help. Love the statement that many people qualify and do not realize it."

- Suggested simplified wording and presentation of information to make it easier to read and understand. Specifically, one individually suggested the following wording:

  "We didn't get your monthly payment for the Medicare Prescription Payment Plan that was due <insert payment due date>.

  To stay in the Medicare Prescription Payment Plan, you must:

  - *Pay <insert the full amount past*
  - *Pay > by <insert date for the end of the grace period.*

- *Contact us at [insert phone number or other contact information] if you are unable to pay [insert amount] by [insert date] and wish to set up a partial payment [or other arrangement] to continue your MPPP participation.*

- Were concerned that there was no mention of extenuating circumstances that might justify a delinquent payment. If participant hardships are taken into consideration when a plan determines to involuntarily terminate MPPP participation, the document should spell this out and let individuals know how to communicate this to the plan.

- The Notice does not let patients know whether they have reached their OOP maximum. Individuals were also uncertain of whether any unpaid amounts under the MPPP would count toward their OOP maximum. The Notice will misinform beneficiaries who have met their OOP maximum if it conveys that after termination from the MPPP the beneficiary will be required to pay OOP costs at the pharmacy.

Document 5: Notice of Involuntary Termination ("Part D Sponsor Notice for Failure to Make Payments under Medicare Prescription Payment Plan – Notification of Termination of Participation in the Medicare Prescription Payment Plan")

While virtually all patients reviewing this document found that it was clear and understandable, several patients expressed concern that there was no stated mechanism for participants to continue working with the plan to get current and resume participation. Several individuals suggested that CMS clarify any impact termination might have on the total amount needed to reach their OOP maximum. Patients were also unsure of what they might expect if they are involuntarily terminated from the MPPP, including whether the debt would be turned over to a collection agency, and even whether their pharmacy might try to collect the debt before filling their future prescriptions.

Document 6: Notice of Voluntary Termination ("Part D Sponsor Notification of Voluntary Removal from the Medicare Prescription Payment Plan")

The information in the Notice of Voluntary Termination was viewed as clear and understandable for Haystack Project's patient communities.

Conclusion

Once again, we appreciate that CMS has sought feedback on the six model documents and look forward to continuing to work with you in ensuring that all Medicare beneficiaries, including those with rare diseases, can receive the treatments they need without financial hardships associated with high out-of-pocket costs. If you have any questions, please contact me at Kara.berasi@haystackproject.org or our policy consultant, M Kay Scanlan of Consilium Strategies at mkayscanlan@consilstrat.com.

Sincerely,

Kera Berasi, PharmD, MS
CEO, Haystack Project
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Humana

April 26, 2024

William N. Parham, III
Director, Paperwork Reduction Staff
Office of Strategic Operations and Regulatory Affairs
Centers for Medicare and Medicaid Services
7500 Security Boulevard
Baltimore, Maryland 21244

RE: Agency Information Collection Activities; Proposed Collection; Comment Request; The Medicare Advantage and Prescription Drug Programs: Part C and Part D Medicare Prescription Drug Payment Plan Model Documents

Dear Mr. Parham:

This letter is in response to the Centers for Medicare and Medicaid Services (CMS) agency information collection notice on the Medicare Advantage and Prescription Drug Programs: Part C and Part D Medicare Prescription Payment Plan Model Documents (CMS-10882), as issued on February 29, 2024.

Humana appreciates the opportunity to offer feedback and recommendations to CMS on the Medicare Prescription Payment Plan established by the Inflation Reduction Act (IRA). Humana currently services approximately 5.9 million beneficiaries enrolled in our Medicare Advantage (MA) plans and 2.9 million beneficiaries enrolled in our Medicare Part D Prescription Drug Plans (PDPs). As one of the nation's top contractors for MA, we are distinguished by our long-standing, comprehensive commitment to Medicare beneficiaries across the United States. These beneficiaries – a large proportion of whom depend upon the MA program as their safety net and many in underserved areas – receive integrated, coordinated, quality, and affordable care through our plans. Our perspective is further shaped by the comprehensive medical coverage we provide for Medicaid beneficiaries in seven states. Additionally, Humana's successful history in care delivery and health plan administration is helping to create a new kind of integrated care with the power to improve health and well-being and lower costs.

Humana supports the policy goal of establishing the Medicare Prescription Payment Plan (MPPP) as a mechanism to allow Part D enrollees to spread significant costs over time in lieu of a single larger expense. However, we believe that payment plan participation benefits a relatively small portion of the larger Part D population. We also believe the operations related to the payment plan will be some of the most complex provisions from the IRA to implement, involving new enrollment, billing, and claims processing mechanisms. We remain concerned about the possibility of enrollee confusion related to the new program and strongly support CMS's efforts to standardize communications whenever possible.

We value this opportunity to provide comments and are pleased to answer any questions you may have with respect to these comments. We hope that you consider our input as constructive feedback aimed at ensuring that together we continue to advance our shared goals of improving the delivery of coverage and services in a sustainable, affordable manner to Medicare beneficiaries, focused on improving their total health care experience.

Sincerely,

Michael Hoak
Vice President, Public Policy

MPPP Likely to Benefit Notice

CMS proposes a model communication intended for enrollees who have been identified by MA and Part D plans as "likely to benefit" from participation in the Medicare Prescription Payment Plan (MPPP). The notice provides information on the purpose of the program, the reason the enrollee is receiving the notice, how the program may benefit the enrollee, scenarios that may make MPPP enrollment less beneficial, and information on how to learn more and elect to participate.

Humana Comment: Humana believes that MPPP participation benefits a relatively small portion of the full Medicare Part D population and it will be essential to assist those enrollees in grasping MPPP program parameters. Likewise, MPPP communication materials should also clearly indicate that the MPPP may not be appropriate for Part D enrollees who incur only modest out-of-pocket (OOP) drug costs. CMS alludes to this issue in the section entitled "How do I know if the payment option might not be right for me?". Humana recommends revising this section to more clearly distinguish enrollees likely to benefit from those who are unlikely to benefit. In this case, it may be preferable to offer a contrasting set of statements ("you may benefit if..., you are not likely to benefit if...).

Humana further recommends that the "MPPP Likely to Benefit" notice expressly indicate that the payment plan is an optional program designed to assist enrollees with their Part D costs and the program does not reduce these costs in any way. This information appears in the draft document, but we recommend that CMS take care not to conflate the MPPP with an enrollee's chosen Part D plan. Accordingly, we recommend this document explain that MPPP does not replace or supplement Part D coverage - it simply allows participants to spread costs over time.

Humana believes that Part D plan sponsors can ably assist enrollees in weighing the benefits and responsibilities associated with MPPP participation. However, we also believe that a plan sponsor is only one of many resources for enrollees considering participation in the MPPP. Accordingly, we recommend that the section titled "Who can help me decide if I should sign up for this payment option?" should be retitled "Where can I learn more?". While Humana stands ready to assist our members with MPPP-related questions, we do not feel that plan sponsors will be fully equipped to influence an enrollee's decision on whether to participate in the MPPP.

We additionally recommend that CMS weigh the following changes to the model notice:

- Include information on the timing of MPPP enrollments. Humana recommends that CMS use language indicating that program elections near the end of the calendar year will not be beneficial to an enrollee. Doing so would be consistent with CMS's part one and part two guidance on the MPPP;
- Include an illustration or visual aide designed to explain MPPP program mechanics. Enrollees may benefit from a more visual explanation of how the program works to spread Part D costs over a period of time following an enrollee's decision to opt-in to the program;
- Allow Part D plan sponsors to include direct contact information on this document. We recognize that the "Likely to Benefit" notice is a model material for use by all plan sponsors and stakeholders. However, we see benefit in having the flexibility to direct reference Humana points of contact (phone, internet-based, etc.) using this document.

Lastly, Humana recommends **simplifying** the information provided in this document to the greatest extent possible. We see the potential for significant confusion among Medicare beneficiaries unaccustomed to making additional elections as part of their Part D plan enrollment. It will be essential for this document, and the other model materials, to explain high-level program parameters in a way that can be easily understood by a typical enrollee.

MPPP Election Request Form

CMS proposes a model election request form that allows enrollees to notify their plan sponsor that they would like to opt into the program. It also includes references to other programs designed to lower out-of-pocket costs for Part D enrollees.

Humana Comment: Humana appreciates the relative simplicity of the proposed participation request document but also encourages CMS to expand on the provided information with the goal of giving a potential participant a clear understanding of enrollment expectations. Humana further recommends that CMS remove information that is not required for enrollment in the program – such as address, phone number, birthday, etc. This information is already provided by members upon their enrollment in their selected Part D plan.

First, Humana suggests including a very brief description of the MPPP on the participation request document. This could be as simple as a couple of sentences indicating that the MPPP is an optional payment plan designed to help Part D enrollees spread their OOP costs over a set time period. Here again, we encourage CMS to take care in avoiding enrollee confusion by making the purpose of the document abundantly clear to potential participants.

Second, we recommend that CMS explicitly indicate the means by which the enrollment document may be submitted to an enrollee's plan sponsor. Per CMS guidance on the MPPP, requests to participate in the MPPP may be submitted using a paper form, telephonically, or via a plan sponsor's website. Although we appreciate the customizable portion of the proposed document directing potential participants how to submit the document, we also feel that enrollees may find it more convenient to opt-in to the MPPP over the phone or via a web-based portal. CMS should clearly indicate that both are alternatives to submitting the completed document via mail or fax.

Third, we feel it would be helpful to potential participants for CMS to expand on the language indicating that the plan sponsor will notify a new participant when their participation in the MPPP becomes effective. CMS guidance on the MPPP sets out clear timelines for the effectuation of participation requests by a plan sponsor. We feel that CMS should thus indicate an approximate timeline in which a prospective participant can expect to be notified of active participation and also indicate the way in which the notification will be provided.

Finally, we recommend that CMS clarify the signature panel to indicate that either a Part D enrollee or that enrollee's legal representative may complete and sign the request to participate. Section 70.3.1 of the final part one guidance on the MPPP sets the standards for election requests and provides that an enrollee's legal representative may make a participation request on behalf of an enrollee. To avoid confusion, we suggest that the proposed enrollment document include this indication and clearly distinguish between an enrollee election made directly by the enrollee and an election made by an enrollee's legal representative. Such a

distinction may help ensure that a participation request is processed quickly and accurately, in keeping with the standards set by CMS in the MPPP guidance.

MPPP Notice of Election Approval

CMS proposes a model notice that provides official plan documentation to an enrollee that the election request has been approved and participation in the MPPP is effective. This model notice also includes information on billing processes and payments for prescriptions, processes for filing a dispute, and processes for opting out of the program.

Humana Comment: Humana applauds efforts by CMS to succinctly describe enrollment and disenrollment processes for a novel program that may confuse enrollees at the outset. We also appreciate the customizable nature of the proposed election approval document, which we anticipate will assist Part D plan sponsors in communicating with members throughout the election process. However, we seek clarity from CMS as to whether all the identifiers listed at the top of the proposed document are necessary. From the Humana perspective, we would need only a member ID number and an effective date to effectuate MPPP participation. While there may be some value in reminding a participant of additional information about their plan (RxID, RxGroup, RxBin, PxPCN), we are also hesitant to overwhelm a member with additional information when confirming participation in the MPPP. Here again, we recommend a streamlined and simple approach that conveys only necessary information to a new program participant.

Humana also recommends modifications to the section of the proposed document entitled "What happens now?":

- As written, this section seems to assume that the Part D plan sponsor already has information on the prospective participant's preferred pharmacy. We recommend directing a prospective participant to contact the plan sponsor to confirm pharmacy provider preferences.
- CMS references the monthly bill that will be sent by a Part D plan sponsor to a program participant. We recommend emphasizing that the amount owed each month is likely to vary and will represent only a portion of an enrollee's total incurred costs under the program. A visual aide could be useful in illustrating how monthly payments will effectively replace traditional point-of-sale payments to pharmacies.

In keeping with our suggestions related to the "MPPP Likely to Benefit" notice, we feel that an illustration or visual aide designed to explain MPPP program mechanics could be included on this document to convey financial expectations to a participant. While an enrollee's participation is confirmed at the point of receiving this document, we see value in reiterating the mechanics of the MPPP for first time participants.

In the section of the proposed document titled "Can I leave the Medicare Prescription Payment Plan?", Humana recommends directing participants to a plan sponsor website in addition to providing a phone number to facilitate voluntary disenrollments from the MPPP. We see the web-based route as potentially more convenient for many enrollees while also offering participants written confirmation of their disenrollment upon completion. We also recommend an explicit indication that, upon disenrollment from the MPPP, enrollees will be expected to resume paying for prescriptions at the point-of-sale. Humana's previous comments to CMS on

the MPPP have emphasized the need for enrollees to be responsible participants in the MPPP. In keeping with that principle, we recommend that CMS also include information about involuntary termination on this document. Participants should be amply notified that delinquent payments under the MPPP can lead to disenrollment from the program following the grace period described by CMS in the final part one guidance on the MPPP.

MPPP Initial Notice of Failure to Pay

CMS proposes a model document that notifies a MPPP participant that a payment for a monthly billed amount has not been received, instructs the enrollee on how to submit the payment during a grace period, and clarifies that if payment in not received, the participant will be terminated from the program.

Humana Comment: Humana appreciates the customizable nature of the proposed "Initial Notice for Failure to Make Payments under the MPPP" document, which we anticipate will assist Part D plan sponsors in communicating with members in cases where payment delinquency occurs. We recognize the payment plan is designed to ease financial pressures on participants, but caution that the program could result in plan sponsors carrying significant delinquent or unpaid balances. We encourage CMS to emphasize the urgency of past due payments in this document and choose language that will clearly indicate the need for participant action upon receipt of the notice document.

Here again, we seek clarification from CMS as to whether the proposed document needs to convey information that would not generally be included in enrollee-facing communications (RxID, RxGroup, RxBin, PxPCN). Humana would be inclined to use a simplified presentation of member identifiers – perhaps just a member ID number and name. We also suggest allowing a plan sponsor to convey the proposed document to a program participant using their preferred method for plan-to-member communications. This could result in the document being delivered to a member through traditional mail, via e-mail, or both.

Humana again recommends including a visual aide to convey information about outstanding amounts under the MPPP and minimum amounts due. We envision a graphic similar to those often found on billing statements or explanation of benefits statements. We feel that using a graphical approach will further increase participant comprehension of any amounts that are past due and in need of attention. We recommend calling additional attention to a potential termination date if the minimum payment is not satisfied during the applicable grace period. The first sentence under the section titled "What happens if I don't pay my bill" seems to lack the urgency that ought to be associated with termination from the MPPP. We encourage CMS to use plain language here that clearly conveys the finality of potential termination from the payment plan.

Finally, we suggest making the section titled "Are there programs that can help lower my costs?" customizable for plan sponsors. Humana sees value in including plan-specific options among the list of cost mitigation options that may be available to an MPPP program participant. We would like to strike a balance between informing participants about additional programs that are available while also emphasizing that these programs are separate and distinct from the MPPP.

MPPP Notice of Involuntary Termination

CMS proposes a model document that would notify an enrollee that they have been removed from the program due to their failure to pay their monthly billed amount within the allotted grace period. The model notice also explains the grievance and reinstatement processes and clarifies that the enrollee still owes the overdue amount and describes the process for paying the outstanding balance.

> **Humana Comment:** Humana appreciates the customizable nature of the proposed "Notification of Termination in the MPPP" document, which we anticipate will assist Part D plan sponsors in communicating with members in cases where payment delinquency occurs. Here again, we seek clarification from CMS as to whether the proposed document needs to convey information that would not generally be included in enrollee-facing communications (RxID, RxGroup, RxBin, PxPCN). Humana would be inclined to use a simplified presentation of member identifiers – perhaps just a member ID number and name. Before taking such an approach, we would appreciate CMS's opinion on the need for a more detailed presentation of member identifiers in this document.
>
> Humana encourages CMS to consider reordering the first two paragraphs of the proposed model notice. We believe it is essential to emphasize the primacy of the action conveyed through this document. By immediately indicating that an enrollee's participation in the MPPP has been terminated, the remainder of the document can be focused on next steps necessary to satisfy an outstanding balance and information on other cost-mitigation programs that may be available to the enrollee. Finally, we again suggest making the section titled "Are there programs that can help lower my costs?" customizable for plan sponsors. Humana sees value in including plan-specific options among the list of cost mitigation options that may be available to an MPPP program participant. We would like to strike a balance between informing participants about additional programs that are available while also emphasizing that these programs are separate and distinct from the MPPP.

MPPP Notice of Voluntary Termination

CMS proposes a model notice providing the plan official documentation that a MPPP participant has chosen to terminate their participation in the program. The model notice would alert the enrollee that they are still responsible for an outstanding balance and would describe the process for paying any outstanding balances.

> **Humana Comment:** Humana applauds CMS for choosing to develop a separate notice for *voluntary* terminations of participation in the MPPP. As members transition out of MPPP participation, it will be essential for plan sponsors to communicate remaining responsibilities to these members and the proposed document seems to offer an effective vehicle for high-level communications. However, we offer several suggestions for improving the content of the notice in ways that could benefit both participants and plan sponsors.
>
> Humana recommends CMS develop opening statements in the document that will allow for additional detail on the reason underlying each voluntary termination. For example, it may be useful to the participant to indicate whether he/she has opted out while remaining a member of the same Part D plan; switched to another Part D plan operated by the same plan sponsor; or transitioned to a Part D plan with a different plan sponsor. We feel that this level of detail will reassure participants that the voluntary termination was initiated on their behalf or by virtue of

a decision to switch Part D plans, and not by virtue of any oversight or for non-payment of an outstanding balance. It may also be advisable to use a visual graphic here to illustrate why the termination is occurring and the ways in which participation in the MPPP can be reactivated by the participant.

In the section of the proposed document titled “How do I pay my balance”, Humana recommends omitting the reference to late payments. While the statement drafted by CMS is technically correct, we feel that this phrasing could unintentionally lead to more late or otherwise delinquent payments. We intend to illustrate the various ways in which participants can satisfy any outstanding balance upon termination from MPPP participation. And while we also intend to provide participants with payment flexibility in keeping with the spirit of the MPPP, we also feel that the model documents should reaffirm a participant’s financial responsibilities whenever possible.

In the section of the proposed document titled “Can I use this payment option in the future?”, Humana again recommends rephrasing the language to emphasize the need for payment of any outstanding balance under the MPPP. Even when current participation in the MPPP is ended voluntarily, a participant should be required to satisfy any outstanding balance under the MPPP or be making timely monthly payments towards that balance as a condition of continuing MPPP participation with another plan or plan sponsor. We continue to encourage CMS to develop model communications materials on the that emphasize both the benefits and the *responsibilities* associated with MPPP participation.

Exhibit 1 – Part D Sponsor Notice to Acknowledge Acceptance of Election in the Medicare Prescription Payment Plan

Referenced in [insert draft part 2 guidance section]

<Part D sponsors may insert a title for the notice, such as "You're now participating in the Medicare Prescription Payment Plan">

<Member #>

<RxID>

<RxGroup>

<RxBin>

<RxPCN>

<Date>

Dear <Name of Member>,

Welcome to the Medicare Prescription Payment Plan, a payment option that works with your <plan name>. Your participation starts on <insert date>.

What happens now?

1. We'll let your pharmacy (including mail-order and specialty pharmacies) know that you're using this payment option.
2. When you fill a prescription for a drug covered by Part D, you won't pay your pharmacy for the prescription.
3. Each month <plan name> will send you a bill with the amount you owe, when it's due, and information on how to make a payment. You'll get a separate bill for your monthly plan premium (if you have one).

How is my monthly bill calculated?

Your monthly bill is based on what you owe for any prescriptions you get, plus your previous month's balance, divided by the number of months left in the year.

Your payments might change every month, so you might not know what your exact bill will be ahead of time. Future payments might increase when you fill a new prescription or refill an existing prescription because as new out-of-pocket costs are added into your monthly payment, there are fewer months left in the year to spread out your payments. You'll never pay any interest or fees on the amount you owe, even if your payment is late.

Remember, in a single calendar year (Jan – Dec), you'll never pay more than:

- The total amount you would have paid out of pocket to the pharmacy.
- The Medicare drug coverage annual out-of-pocket maximum (which is $2,000 in 2025).

What happens if I don't pay my bill?

We'll send you a reminder if you miss a payment. If you don't pay your bill by the date listed in that reminder, you'll be removed from the Medicare Prescription Payment Plan. Like any other debt, you're

required to pay the amount you owe. Always pay your <plan name> premium first (if you have one), so you don't lose your drug coverage.

If you think that we've made a mistake with the amount you owe, call us at <phone number>. You also have the right to follow the grievance process found in your <insert "Member Handbook" or "Evidence of Coverage," as appropriate>.

Can I leave the Medicare Prescription Payment Plan?

You can leave the Medicare Prescription Payment Plan at any time by calling us at <phone number>. If you still owe a balance, you're required to pay the amount you owe, even though you're no longer participating in the program. You can choose to pay the remaining amount all at once or be billed monthly. If you leave, your Medicare drug coverage and other Medicare benefits won't be affected, and you'll go back to paying the pharmacy directly for all your out-of-pocket drug costs.

If you leave <current plan name> or change to a new Medicare drug plan or Medicare health plan with drug coverage (like a Medicare Advantage Plan) your participation in the Medicare Prescription Payment Plan will end. If you change plans, and you'd like to join the Medicare Prescription Payment Plan offered through your new plan, contact your new plan.

Are there programs that can help lower my costs?

While the Medicare Prescription Payment Plan spreads out your costs, it doesn't lower them. However, you may be eligible for programs that can help lower your costs, like:

- **Extra Help:** A Medicare program that helps pay your Medicare drug costs if you have limited income and resources. Visit secure.ssa.gov/i1020/start to find out if you qualify and apply. You can also apply with your state's Medicaid office. Visit Medicare.gov/basics/costs/help/drug-costs to learn more.
- **Medicare Savings Program**: A state-run program that helps people with limited income and resources pay some or all of their Medicare premiums, deductibles, and coinsurance. Visit Medicare.gov/medicare-savings-programs to learn more.
- **State Pharmaceutical Assistance Program (SPAP):** A program that may include coverage for your Medicare drug plan premiums and/or cost sharing. SPAP contributions may count toward your Medicare drug coverage out-of-pocket limit. Visit go.medicare.gov/spap to learn more.
- **Manufacturer's Pharmaceutical Assistance Programs** (sometimes called Patient Assistance Programs (PAPs)): A program from drug manufacturers to help lower drugs costs for people with Medicare. Visit go.medicare.gov/pap to learn more.

Many people qualify for savings and don't realize it. Visit Medicare.gov/basics/costs/help, or contact your local Social Security office to learn more. Find your local Social Security office at secure.ssa.gov/ICON/main.jsp or call 1-800-772-1213. TTY users can call 1-800-325-0778.

Exhibit 2 – Part D Sponsor Initial Notice for Failure to Make Payments under the Medicare Prescription Payment Plan

Referenced in [insert draft part 2 guidance section]

<Part D sponsors may insert a title for the notice, such as "Urgent: Pay your Medicare Prescription Payment Plan bill">

<Member #>

<RxID>

<RxGroup>

<RxBin>

<RxPCN>

Dear < Member>:

We didn't get your monthly payment for the Medicare Prescription Payment Plan that was due <insert payment due date>. To stay in the Medicare Prescription Payment Plan, you must pay <insert the full amount or a partial amount(s) should the plan choose to allow enrollees to pay the balance over separate payments> by <insert date for the end of the grace period (i.e., the date that is two calendar months from the first day of the month for which the balance is unpaid or the first day of the month following the date on which the payment is requested, whichever is later)>.

This letter only applies to your participation in the Medicare Prescription Payment Plan. Your Medicare drug coverage and other Medicare benefits won't be affected, and you'll continue to be enrolled in <plan name> for your drug coverage.

How do I pay my bill?

You can choose to pay the amount you owe all at once or be billed monthly. You'll never pay any interest or fees on the amount you owe.

You owe <insert unpaid>. You can pay:

- Online at <plan's website>, by credit/debit card.
- Through the mail, by check.
- <insert other payment methods offered by the plan like electronic funds transfer (including automatic charges of an account at a financial institution or credit or debit card account)>.

If you have questions about your payment, call us at <phone number>, <days and hours of operation>. TTY users can call < TTY number>.

What happens if I don't pay my bill?

If you don't pay your bill by <insert effective date>, you'll no longer be in the Medicare Prescription Payment Plan through <plan sponsor>. As of <effective date>, you'll pay the pharmacy directly for your out-of-pocket drug costs.

Like any other debt, you're required to pay the amount you owe. As long as you continue to pay your plan premium (if you have one), you'll still have drug coverage through <plan name>.

What if I think there's been a mistake?

If you think that we've made a mistake, call us at <phone number>. You also have the right to ask us to reconsider our decision through a grievance process. Check your <insert "Member Handbook" or "Evidence of Coverage," as appropriate>.

What if I can't afford to pay both my plan premium and my Medicare Prescription Payment Plan payment?

Always pay your <plan name> premium first (if you have one). If needed, we can apply a payment you've made toward your **Medicare Prescription Payment Plan** balance to your plan premium instead. Call us at <phone number> to discuss this option.

Are there programs that can help lower my costs?

While the Medicare Prescription Payment Plan spreads out your costs, it doesn't lower them. However, you may be eligible for programs that can help lower your costs, like:

- **Extra Help:** A Medicare program that helps pay your Medicare drug costs if you have limited income and resources. Visit secure.ssa.gov/i1020/start to find out if you qualify and apply. You can also apply with your state's Medicaid office. Visit Medicare.gov/basics/costs/help/drug-costs to learn more.
- **Medicare Savings Program**: A state-run program that helps people with limited income and resources pay some or all of their Medicare premiums, deductibles, and coinsurance. Visit Medicare.gov/medicare-savings-programs to learn more.
- **State Pharmaceutical Assistance Program (SPAP):** A program that may include coverage for your Medicare drug plan premiums and/or cost sharing. SPAP contributions may count toward your Medicare drug coverage out-of-pocket limit. Visit go.medicare.gov/spap to learn more.
- **Manufacturer's Pharmaceutical Assistance Programs** (sometimes called Patient Assistance Programs (PAPs)): A program from drug manufacturers to help lower drugs costs for people with Medicare. Visit go.medicare.gov/pap to learn more.

Many people qualify for savings and don't realize it. Visit Medicare.gov/basics/costs/help, or contact your local Social Security office to learn more. Find your local Social Security office at secure.ssa.gov/ICON/main.jsp or call 1-800-772-1213. TTY users can call 1-800-325-0778.

Note: The programs listed above can help lower your costs, but they can't help you pay off your Medicare Prescription Payment Plan balance.

Consider Managing Your Monthly Drug Costs with the Medicare Prescription Payment Plan

You might benefit from participating in the Medicare Prescription Payment Plan, because you have high drug costs. This new payment option works with your current drug coverage, and it can help you manage your drug costs by spreading them across **monthly payments that vary throughout the year** (January – December).

What's the Medicare Prescription Payment Plan?

The Medicare Prescription Payment Plan is a new payment option to help you manage your out-of-pocket drug costs, starting in 2025. All Medicare drug plans and Medicare health plans with drug coverage (like a Medicare Advantage Plan) must offer this payment option, and all plans use the same formula to calculate your monthly payments. If you select this payment option, each month you'll pay your plan premium (if you have one) and you'll get a bill from your health or drug plan for your prescription drugs (instead of paying the pharmacy).

Participating in this payment option is voluntary. Anyone with a Medicare drug plan or a Medicare health plan with drug coverage can use this payment option, which applies to all prescription drugs covered by Part D. It doesn't cost anything to participate in the Medicare Prescription Payment Plan, and you won't pay any interest or fees on the amount you owe, even if your payment is late.

Will this payment option help me?

It depends on your situation. If you have high out-of-pocket drug costs, this payment option spreads out what you'll pay each month across the year (January – December), so you don't have to pay out-of-pocket costs to the pharmacy. **This payment option might help you manage your expenses, but it doesn't save you money or lower your drug costs.** Visit Medicare.gov/basics/costs/help/drug-costs to learn about programs that can help lower your drug costs.

How will my costs work with this payment option?

The new prescription drug law caps your out-of-pocket costs at $2,000 in 2025 and eliminates the coverage gap (known as the "donut hole"). This means you'll never pay more than $2,000 in out-of-pocket drug costs in 2025. **This is true for everyone with Medicare drug coverage, even if you don't join the Medicare Prescription Payment Plan.**

When you fill a prescription for a drug covered by Part D, you won't pay your pharmacy (including mail-order and specialty pharmacies). Instead, you'll get a bill each month from your plan. Your monthly bill is based on what you owe for any prescriptions you get, plus your previous month's balance, divided by the number of months left in the year.

Note: Your payments might change every month, so you might not know what your exact bill will be ahead of time. Future payments might increase when you fill a new prescription or refill an existing prescription because as new out-of-pocket drug costs are added into your monthly payment, there are fewer months left in the year to spread out your payments.

How do I know if this payment option might not be right for me?

This payment option might not be helpful for you if:

- You get Extra Help from Medicare.
- You qualify for a Medicare Savings Program.

- You get help paying for your drugs from other organizations, like a State Pharmaceutical Assistance Program (SPAP) or other health coverage.
- Your yearly drug costs are low.
- Your drug costs are the same each month.
- You're considering signing up for the payment option late in the calendar year (after September).
- You don't want to change how you pay for your drugs.

Who can help me decide if I should sign up for this payment option?

- **Your plan:** Visit your plan's website, or call your plan to get more information. Your plan's phone number is on the back of your membership card.
- **Medicare:** Visit Medicare.gov/tbd, or call 1-800-MEDICARE (1-800- 633-4227), 24 hours a day, 7 days a week. TTY users can call 1-877-486-2048.
- **State Health Insurance Program (SHIP):** Visit shiphelp.org to get the phone number for your local SHIP and get free, personalized health insurance counseling.

How do I sign up for this payment option?

To sign up for this payment option, visit your plan's website or call your plan. You can find your plan's phone number on the back of your membership card. If you need to pick up a prescription urgently, the fastest way to use this payment option is to call your plan.

Need this information in another format or language?

To get this material in other formats like large print, braille, or another language, contact your Medicare drug plan. If you need help contacting your plan, call: 1-800-MEDICARE (1-800-633-4227).

Exhibit 3 - Part D Sponsor Notice for Failure to Make Payments under Medicare Prescription Payment Plan - Notification of Termination of Participation in the Medicare Prescription Payment Plan

Referenced in [insert draft part 2 guidance section]

<Part D sponsors may insert a title for the notice, such as "Important: Your participation in the Medicare Prescription Payment Plan has ended">

<Member #>

<RxID>

<RxGroup>

<RxBin>

<RxPCN>

<Date>

Dear < Member>,

On <date of initial notification of failure to pay>, we sent you a letter letting you know your monthly payment for the Medicare Prescription Payment Plan was overdue. The letter explained that if you didn't make your payment by <insert time frame>, we'd end your participation in the Medicare Prescription Payment Plan.

Starting <insert effective date, which should be the same date as this letter>, you're no longer participating in the Medicare Prescription Payment Plan through <plan sponsor> because we didn't get your monthly payment. Like any other debt, you're still required to pay the amount you owe, $<amount owed>.

As of <effective date>, you'll pay the pharmacy directly for all your out-of-pocket drug costs.

This letter only applies to your participation in the Medicare Prescription Payment Plan. Your Medicare drug coverage and other Medicare benefits won't be affected, and you'll continue to be enrolled in <plan name> for your drug coverage.

How do I pay my balance?

You can choose to pay the amount you owe all at once or be billed monthly. You'll never pay any interest or fees on the amount you owe.

You owe <insert unpaid>. You can pay:

- Online at <plan's website>, by credit or debit card.
- Through the mail, by check.
- <insert other payment methods offered by the plan sponsor like electronic funds transfer (including automatic charges of an account at a financial institution or credit or debit card account)>.

If you have questions about your payment, call us at <phone number>, <days and hours of operation>. TTY users can call <TTY number>.

What if I think there's been a mistake?

If you think that we've made a mistake, call us at <phone number>. You also have the right to ask us to reconsider our decision through the grievance process in your <insert "Member Handbook" or "Evidence of Coverage," as appropriate>.

Can I use this payment option in the future?

Yes, once you pay the total amount you owe.

Are there programs that can help lower my costs?

You may be eligible for programs that can help lower your costs, like:

- **Extra Help:** A Medicare program that helps pay your Medicare drug costs if you have limited income and resources. Visit secure.ssa.gov/i1020/start to find out if you qualify and apply. You can also apply with your state's Medicaid office. Visit Medicare.gov/basics/costs/help/drug-costs to learn more.
- **Medicare Savings Program**: A state-run program that helps people with limited income and resources pay some or all of their Medicare premiums, deductibles, and coinsurance. Visit Medicare.gov/medicare-savings-programs to learn more.
- **State Pharmaceutical Assistance Program (SPAP):** A program that may include coverage for your Medicare drug plan premiums and/or cost sharing. SPAP contributions may count toward your Medicare drug coverage out-of-pocket limit. Visit go.medicare.gov/spap to learn more.
- **Manufacturer's Pharmaceutical Assistance Programs** (sometimes called Patient Assistance Programs (PAPs)): A program from drug manufacturers to help lower drugs costs for people with Medicare. Visit go.medicare.gov/pap to learn more.

Many people qualify for savings and don't realize it. Visit Medicare.gov/basics/costs/help, or contact your local Social Security office to learn more. Find your local Social Security office at secure.ssa.gov/ICON/main.jsp or call 1-800-772-1213. TTY users can call 1-800-325-0778.

Note: The programs listed above can help lower your costs, but they can't help you pay off your Medicare Prescription Payment Plan balance.

Exhibit 4 - Part D Sponsor Notification of Voluntary Removal from the Medicare Prescription Payment Plan

Referenced in [insert draft part 2 guidance section]

<Part D sponsors may insert a title for the notice, such as "You're no longer participating in the Medicare Prescription Payment Plan through <plan sponsor>">

<Member #>

<RxID>

<RxGroup>

<RxBin>

<RxPCN>

Dear <Member>,

Starting <insert effective date>, you're no longer participating in the Medicare Prescription Payment Plan through <plan sponsor>. As of <effective date>, you'll pay the pharmacy directly for your out-of-pocket drug costs.

You're getting this letter because you either asked to stop participating in this payment option, **or** you changed your Medicare drug plan or Medicare health plan with drug coverage (like a Medicare Advantage Plan). If you changed plans, and you'd like to join the Medicare Prescription Payment Plan offered through your new plan, contact your new plan.

This letter only applies to your participation in the Medicare Prescription Payment Plan. Your Medicare drug coverage and other Medicare benefits won't be affected, and you'll continue to be enrolled in <plan name> for your drug coverage.

How do I pay my balance?

You can choose to pay the amount you owe all at once or be billed monthly. You'll never pay any interest or fees on the amount you owe, even if your payment is late.

You owe <insert unpaid>. You can pay:

- Online at <plan's website>, by credit or debit card.
- Through the mail, by check.
- <insert other payment methods offered by the plan sponsor like electronic funds transfer (including automatic charges of an account at a financial institution or credit or debit card account)>.

If you have questions about your payment, call us at <phone number>, <days and hours of operation>. TTY users can call <TTY number>.

What happens if I don't pay my balance?

Like any other debt, you're required to pay the amount you owe. As long as you continue to pay your plan premium (if you have one), you'll still have drug coverage.

Can I use this payment option in the future?

- **If you're still in <plan name>:** Yes. Visit <insert PDP webpage where the application is>, or call us at <phone number> <days and hours of operation>. TTY users can call <TTY number>.
- **If you're joining a new plan:** Yes. All Medicare drug plans and Medicare health plans with drug coverage must offer this payment option. No matter what Medicare drug plan you're in, you can choose to rejoin the Medicare Prescription Payment Plan at any time.

Are there programs that can help lower my costs?

You may be eligible for programs that can help lower your costs, like:

- **Extra Help:** A Medicare program that helps pay your Medicare drug costs if you have limited income and resources. Visit secure.ssa.gov/i1020/start to find out if you qualify and apply. You can also apply with your state's Medicaid office. Visit Medicare.gov/basics/costs/help/drug-costs to learn more.
- **Medicare Savings Program**: A state-run program that helps people with limited income and resources pay some or all of their Medicare premiums, deductibles, and coinsurance. Visit Medicare.gov/medicare-savings-programs to learn more.
- **State Pharmaceutical Assistance Program (SPAP):** A program that may include coverage for your Medicare drug plan premiums and/or cost sharing. SPAP contributions may count toward your Medicare drug coverage out-of-pocket limit. Visit go.medicare.gov/spap to learn more.
- **Manufacturer's Pharmaceutical Assistance Programs** (sometimes called Patient Assistance Programs (PAPs)): A program from drug manufacturers to help lower drugs costs for people with Medicare. Visit go.medicare.gov/pap to learn more.

Many people qualify for savings and don't realize it. Visit Medicare.gov/basics/costs/help, or contact your local Social Security office to learn more. Find your local Social Security office at secure.ssa.gov/ICON/main.jsp or call 1-800-772-1213. TTY users can call 1-800-325-0778.

Note: The programs listed above can help lower your costs, but they can't help you pay off your Medicare Prescription Payment Plan balance.

JUSTICE IN AGING

FIGHTING SENIOR POVERTY THROUGH LAW

April 29, 2024

Meena Seshamani
Deputy Administrator and Director of the Center for Medicare
Centers for Medicare and Medicaid Services
U.S. Department of Health and Human Services

Submitted electronically via Regulations.gov

Re: The Medicare Advantage and Prescription Drug Programs: Part C and Part D Medicare Prescription Payment Plan Model Documents (CMS-10882)

Justice in Aging appreciates the opportunity to provide feedback on the Center for Medicare and Medicaid's (CMS') Medicare Prescription Payment Plan (MPPP) Model Documents.[1] Justice in Aging is an advocacy organization with the mission of improving the lives of low-income older adults. We use the power of law to fight senior poverty by securing access to affordable healthcare, economic security, and the courts for older adults with limited resources. We focus our efforts primarily on those who have been marginalized and excluded from justice such as older adults of color, older women, LGBTQ+ older adults, older adults with disabilities, and older adults who are immigrants or have limited English proficiency (LEP). Justice in Aging has decades of experience with Medicare and Medicaid and improving both programs for people dually eligible. We have the following comments on the MPPP model documents.

Thank you for including information about assistance programs for people with limited income. We were pleased to see Low-Income Subsidy (LIS or Extra Help), Medicare Savings Programs (MSP), and other assistance programs listed (with information about how to access the programs) in the following draft documents: (1) Notice of Election Approval; (2) Notice of Failure to Pay; (3) Notice of Involuntary Termination; and (4) Notice of Voluntary Termination.[2]

Include information that LIS can be retroactive. Medical debt is a large and growing problem among older adults, even though the vast majority are insured through Medicare and other insurance.[3] MPPP documents are a prime opportunity to let enrollees know that LIS can provide assistance both going forward and for past expenses. We ask that CMS add language to MPPP notices that, in some cases, LI-NET can provide retroactive coverage and Extra Help can provide assistance with past medication costs.

[1] CMS, "The Medicare Advantage and Prescription Drug Programs: Part C and Part D Medicare Prescription Payment Plan Model Documents" (Feb. 29, 2024)
[2] 89 FR 14847 (February 29, 2024)
[3] Consumer Financial Protection Bureau, "Medical Billing and Collections Among Older Americans," (May 2023)

Include LIS access information on the Medicare Prescription Payment Plan Likely to Benefit notice ("Likely to Benefit notice"). While the Likely to Benefit Notice does reference LIS briefly, the notice does not explain what LIS does or how to access it. We ask that CMS add this information.

Inform individuals of their payment expectations following voluntary termination. We appreciate that CMS makes clear in the draft Part 2 guidance that voluntary termination does not mean that a person is required to pay an immediate lump sum payment in full:

> "After a participant voluntarily terminates their participation in the program, Part D sponsors must work with the enrollee to determine how they will pay their outstanding balance, which may include a lump sum payment; however, Part D sponsors cannot require full immediate repayment. If the enrollee chooses to continue paying in monthly amounts, Part D sponsors must continue to bill amounts owed under the program in monthly amounts not to exceed the maximum monthly cap according to the statutory formula for the duration of the plan year."[4]

We ask that CMS include this information in the Notice of Voluntary Termination, along with information about the steps a person who chooses to continue paying monthly amounts can take if a plan demands a lump sum or charges higher than the maximum monthly cap.

Direct individuals to State Health Insurance Assistance Programs (SHIPs). We recommend that all notices direct people to SHIPs for assistance. The MPPP is likely to appeal to people with lower incomes and may be eligible for other financial assistance. Therefore, it is particularly important to leverage MPPP outreach to connect people with SHIPs as they are well-positioned to educate people about the LIS and Medicare Savings Programs. SHIPs should also be encouraged to strengthen relationships with community-based organizations serving people with limited English proficiency. Thank you for including reference to the SHIP program in the Likely to Benefit document. We ask that you consider adding information about the SHIP program in the (1) Notice of Failure to Pay; (2) Notice of Involuntary Termination; and (3) Notice of Voluntary Termination.

Conclusion

Thank you for the opportunity to provide feedback. If any questions arise concerning this submission, please contact Rachel Gershon, Senior Attorney, at rgershon@justiceinaging.org

Sincerely,

Amber C. Christ
Managing Director, Health Advocacy

[4] MPPP Part 2 Proposed Guidance at 20

Kaiser Permanente Comments on
Agency Information Collection Activities: Proposed Collection; Comment Request

Attention: Document Identifier/OMB Control Number: CMS-10882
(OMB control number: 0938-New)

April 29, 2024

Submitted electronically via regulations.gov

Kaiser Permanente[1] appreciates the opportunity to provide comments on the Centers for Medicare & Medicaid Services' (CMS) intention to collect information from the public with respect to the Medicare Advantage and Prescription Drug Programs: Part C and Part D Medicare Prescription Payment Plan Model Documents published in the *Federal Register* (89 FR 14847) on February 29, 2024 (Form CMS-10882, OMB control number: 0938-New).

Kaiser Permanente offers the following recommendations and requests for clarification on the proposed data collection:

Exhibit 2 – Medicare Prescription Payment Plan Participation Request Form

- **Minimum data elements.** It is not clear what the minimum required data elements are that must be completed on the model Medicare Prescription Payment plan participation request form in order for CMS to consider the form complete. We recommend that CMS consider the form complete if the following items are populated on the form: 1) beneficiary name, 2) beneficiary Medicare number, and 3) beneficiary or authorized representative signature/confirmation of intent to opt in. Additionally, we encourage CMS to clarify on the form which data elements are necessary in order for the form to be considered complete.

- **Modifications.** We request that CMS confirm whether Part D plans will have the ability to modify the model form by adding items the plans find necessary or helpful to streamline and/or expedite processing of requests to participate in the Medicare Prescription Payment Plan. As per our recommendation above, any Part D plan flexibility to streamline the form would be limited to items other than those data elements necessary for the form to be considered complete (e.g., beneficiary name, Medicare number, and signature/confirmation of intent to opt in).

- **Relationship to participant.** The model form includes a field for "Relationship to participant" underneath the signature section; however, there are no instructions on who must fill out this field. It is our understanding that if an authorized representative is completing a Medicare Advantage-Prescription Drug (MAPD) or Prescription Drug Plan (PDP) enrollment request, that individual must attest to having the authority to make the

[1] Kaiser Permanente comprises Kaiser Foundation Health Plan, Inc., one of the nation's largest not-for-profit health plans, and its health plan subsidiaries outside California and Hawaii; the not-for-profit Kaiser Foundation Hospitals, which operates 40 hospitals and over 600 other clinical facilities; and the Permanente Medical Groups, self-governed physician group practices that exclusively contract with Kaiser Foundation Health Plan and its health plan subsidiaries to meet the health needs of Kaiser Permanente's members.

request and provide proof of this authority upon request. Therefore, we recommend that CMS include on this form the same fields as on the current MAPD and PDP enrollment forms for authorized representatives (i.e., an attestation, contact information, and relationship to enrollee).

- **Assistance paying for drugs.** The model form includes a question on whether the beneficiary receives assistance in paying for their prescription drugs through programs like Extra Help or a State Pharmaceutical Assistance Program. We recommend that CMS remove this question from the model form, as it is not necessary to process the request to participate in the Medicare Prescription Payment Plan and it CMS has not provided sufficient explanation or instructions for why this information is being collected on the model form.

Exhibit 3 – Part D Sponsor Notice to Acknowledge Acceptance of Election in the Medicare Prescription Payment Plan

- **Program start date.** The model notice indicates the date that participation in this program starts; however, guidance on the Medicare Prescription Payment Plan provided by CMS to date has not clearly addressed whether participation will automatically renew beyond the plan year for which the beneficiary opts in.[2] If CMS' expectation for plan year 2025 is that participation is limited to the current plan year and will not automatically renew the following plan year, we recommend that the agency: 1) provide clear guidance on that expectation, and 2) insert language into the model notice that clearly states this expectation. For example, the introductory paragraph could use language such as "Your participation starts on <insert date> and will end at the end of the current plan year unless you voluntarily opt out sooner or are involuntarily terminated from the program."

- **Opt back in.** Under the header "Can I use this payment option in the future?", the model notice states: "Yes, once you pay the total amount you owe." We encourage CMS to add optional language to the model notice after this sentence that would allow Part D plans to advise their members to contact the plan, once they pay the total amount they owe, to opt back into the Medicare Prescription Payment Plan. For example, this language could state: "<plans may insert instructions on how to request opting in to the Medicare Prescription Payment plan here>."

Exhibit 4 – Part D Sponsor Notification of Voluntary Removal from the Medicare Prescription Payment Plan

- **Mid-year plan change.** The second paragraph of the model form includes the following language: "You're getting this letter because you either asked to stop participating in this payment option, or you changed your Medicare drug plan or Medicare health plan with drug coverage (like a Medicare Advantage Plan)." Consistent with this language, the Final Part 1 guidance states that if an individual who opted into the Medicare Prescription Payment Plan switches plans during the plan year, the new plan sponsor will <u>not</u> be required

[2] In the Final Part 1 guidance, CMS indicated the question of automatic renewal and/or re-election would be addressed in future guidance.

to automatically transfer the individual's election to their new plan (see Section 70.4 – Mid-Year Plan Election Changes). However, we recommend that CMS clarify whether, in situations where a beneficiary makes a mid-year plan change within the same parent organization, the parent organization has the ability to automatically transfer the beneficiary's Medicare Prescription Payment Plan election to their new plan. If CMS grants parent organizations this flexibility, we recommend the agency add language addressing this circumstance to the model notice. For example, the model notice could include language such as, "If you changed plans and your new plan has not automatically opted you into the Medicare Prescription Payment Plan but you'd like to join this program offered through your new plan, contact your new plan."

Additional comments

- **Failure to pay premium.** We note that Exhibits 1, 2 and 4 include language addressing: 1) what happens if a beneficiary fails to pay their premium, or 2) how a beneficiary will remain covered by their Part D plan as long as they pay their premium. For example, Exhibits 1 and 2, under the header "What happens if I don't pay my bill?", state: "Like any other debt, you're required to pay the amount you owe. Always pay your <plan name> premium first (if you have one), so you don't lose your drug coverage." (Exhibit 4 has similar language.) Kaiser Permanente currently does not disenroll beneficiaries for failing to pay their premiums; we therefore recommend that CMS revise this model language to: 1) account for plans that do not disenroll beneficiaries for failure to pay premiums, or 2) allow the current language to be optional and only apply to plans that do disenroll beneficiaries who do not pay their premium.

- **Other model forms.** CMS did not include in the exhibits the following model forms: 1) a model notice for Part D plans to request additional information that is needed to consider the Medicare Prescription Payment Plan request complete, and 2) a model denial notice for Medicare Prescription Payment Plan elections. We note that there is a model notice to request additional information for full Part D plan enrollment (see Chapter 3 of the Prescription Drug Benefit Manual, Exhibit 3 – Model Notice to Request Information), and a model Part D enrollment denial notice (see Chapter 3 of the Prescription Drug Benefit Manual, Exhibit 6 – PDP Model Notice for Denial of Enrollment). We request that CMS confirm whether the agency plans to develop these two model notices or if plans can leverage the existing Part D model notices but with modifications tailored to the Medicare Prescription Payment Plan.

* * *

Kaiser Permanente appreciates CMS' consideration of these comments. Please contact Greg Berger at gregory.b.berger@kp.org if we may provide additional information or answer any questions.

LEUKEMIA & LYMPHOMA SOCIETY®

April 29, 2024

Chiquita Brooks-LaSure
Administrator, Center for Medicare & Medicaid Services
7500 Security Boulevard
Baltimore, MD 21244

Re: Medicare Advantage and Prescription Drug Programs: Part C and Part D Medicare Prescription Payment Plan Model Documents (CMS–10882)

The Leukemia & Lymphoma Society (LLS) appreciates the opportunity to provide comments to the Centers for Medicare & Medicaid Services (CMS) in response to the Medicare Advantage and Prescription Drug Programs: Part C and Part D Medicare Prescription Payment Plan Model Documents information collection request. LLS's mission is to cure leukemia, lymphoma, Hodgkin's disease, and myeloma, and to improve the quality of life of patients and their families. We advance that mission by advocating that blood cancer patients have sustainable access to quality, affordable, coordinated healthcare, regardless of the source of their coverage.

Due to the Inflation Reduction Act's (IRA) annual $2,000 out-of-pocket cap, many of the patients we represent will save thousands of dollars each year. Yet, while the annual cap is a landmark new patient protection, many Medicare enrollees will not see its benefits if they cannot afford to fill their initial prescriptions due to high upfront out-of-pocket costs. We regret CMS' decision to not require point-of-sale enrollment (POS) at the pharmacy counter for 2025. Without POS election, many Medicare enrollees will fail to experience a benefit from the Medicare Prescription Payment Plan (MPPP).

As such, making these model documents as informative and understandable as possible is paramount as they will be the primary mechanism by which enrollees begin the process of enrolling in the MPPP. We thank the agency for its continued engagement with patient groups in developing these documents and look forward to sharing our patients' experiences as these documents are deployed.

General Comments

The educational and outreach components of the MPPP model documents are crucial to ensure that Medicare beneficiaries fully understand how to navigate the program, appreciate the benefits it offers, and understand the implications of non-payment. Clear, concise, and accessible materials are fundamental in empowering beneficiaries to navigate the complexities of prescription drug costs under the MPPP.

In addition to the foundational materials provided, we suggest CMS develop supplementary educational resources, such as cost calculators or decision aids, that can be integrated with the model documents. These tools, designed with a patient-centered approach, would serve as invaluable assets

for beneficiaries, enabling them to visualize the financial implications of participating in the MPPP and assess how the program aligns with their healthcare needs and financial circumstances. These resources would help demystify the program's benefits and encourage more beneficiaries to take advantage of the MPPP's offerings by providing personalized insights into potential out-of-pocket costs and savings.

To further enhance the clarity and usefulness of the model documents for the MPPP, we suggest that these materials incorporate real-life scenarios and Frequently Asked Questions (FAQs) that reflect the diverse experiences of Medicare beneficiaries. Such content could significantly improve beneficiaries' understanding of the MPPP, providing them with actionable insights into how the program might affect their prescription drug costs and overall health management. Real-life scenarios can offer a relatable context that abstract descriptions often fail to convey, bridging the gap between policy language and the lived experiences of patients and fostering a more profound understanding and connection with the program. Incorporating FAQs and real-life scenarios responds directly to common questions and concerns, potentially minimizing confusion and simplifying the process for beneficiaries to find the information they need.

Document Comments: Likely to Benefit Notice (Exhibit 1 – Consider Managing Your Monthly Drug Costs with the Medicare Prescription Payment Plan)

As this notice is required to be used by plan sponsors as released by CMS, this particular model document is critical to beneficiaries' understanding of their opportunity to reduce their monthly drug spending. As such, we note suggest the following improvements:

- "This new payment option works with your current drug coverage, and it can help you manage your drug costs by spreading them across **monthly payments that vary throughout the year** (January – December)."
    - - We suggest clarifying this statement to read "**monthly payment that <u>may</u> vary throughout the year"** to capture chronic medication users that meet the $2,000 threshold early in the year, enroll, and have consistent payments thereafter. As we suggest elsewhere, these differences can and should be demonstrated via concrete examples.
- "When you fill a prescription for a drug covered by Part D, you won't pay your pharmacy (including mail-order and specialty pharmacies). Instead, you'll get a bill each month from your plan. Your monthly bill is based on what you owe for any prescriptions you get, plus your previous month's balance, divided by the number of months left in the year."
    - It is unclear from this text if the bill sent each month will be separate and distinct from the bill the enrollee may already receive for premium payments due. CMS has indicated in previous MPPP guidance that plans are required to send a separate bill specifically for the beneficiary's MPPP payment due. As such, we suggest that this

section of the document indicate that this will be a separate bill document that enrollees should expect, with a separate payment obligation.

- **"Note: Your payments might change every month, so you might not know what your exact bill will be ahead of time.** Future payments might increase when you fill a new prescription or refill an existing prescription because as new out-of-pocket drug costs are added into your monthly payment, there are fewer months left in the year to spread out your payments."
    - This has the potential to confuse and dissuade beneficiaries from enrolling in MPPP. As we stated above, providing concrete examples of MPPP payments varying over the course of a year would help beneficiaries visualize how it may work or not for their situations. We suggest CMS utilize the remaining whitespace at the end of page 2 to add, as an appendix, specific and concrete examples of these calculations across the calendar year.

Document Comments: Notice of Involuntary Termination (Exhibit 5 – Part D Sponsor Notice for Failure to Make Payments under Medicare Prescription Payment Plan - Notification of Termination of Participation in the Medicare Prescription Payment Plan)

We note that this document lacks information about the process beneficiaries should engage in to be reinstated after termination from the MPPP due to non-payment. While the document states that enrollees can use MPPP in the future once the total amounts owed are paid, there is no explicit instruction regarding the need to re-enroll. Enrollees may be confused and think that if they pay their past-due balance, MPPP participation is automatically reinstated, which is not the case.

This section should provide clear, step-by-step guidance on how beneficiaries can regain their enrollment status after fulfilling their payment obligations, ensuring they understand that re-enrollment is possible and the steps needed to initiate it. By making this process transparent and straightforward, CMS can better support beneficiaries in maintaining continuous access to essential care

Conclusion

LLS thanks CMS again for its leadership in this important area and looks forward to continued collaboration as MPPP is implemented. If you have any questions or would like to discuss our comments further, please contact Phil Waters, Director, Federal Public Policy at The Leukemia & Lymphoma Society at phil.waters@lls.org.

Sincerely,

LEUKEMIA & LYMPHOMA SOCIETY®

Bethany Lilly
Executive Director, Public Policy

PUBLIC SUBMISSION

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Docket: CMS-2024-0093
The Medicare Advantage and Prescription Drug Programs: Part C and Part D Medicare Prescription Payment Plan Model Documents (CMS-10882)

Comment On: CMS-2024-0093-0001
The Medicare Advantage and Prescription Drug Programs: Part C and Part D Medicare Prescription Payment Plan Model Documents (CMS-10882)

Document: CMS-2024-0093-DRAFT-0002
Comment on CMS-2024-0093-0001

Submitter Information

Email: ahunn@lumeris.com
Organization: Lumeris

General Comment

Lumeris appreciates the opportunity to submit feedback on the Medicare Prescription Payment Plan model material drafts.

In Exhibit 1 – Part D Sponsor Notice to Acknowledge Acceptance of Election in the Medicare Prescription Payment Plan under the header “Can I leave the Medicare Prescription Payment Plan?”, we would recommend that the second paragraph include that any amounts owed at the time of leaving the program must still be paid. Given that the first paragraph’s final sentence states that they will go back to paying the pharmacy directly for new costs incurred, we believe adding a statement regarding past amounts paid through the program is essential to mitigate any participant confusion.

In Exhibit 4 – Part D Sponsor Notification of Voluntary Removal from the Medicare Prescription Payment Plan under the header “How do I pay my balance?”, we would recommend marking the first two as optional dependent given that the Final Part One Guidance provides sponsors with flexibility on which payment methods to offer, “CMS encourages Part D sponsors to offer multiple means of payment, such as an electronic fund transfer mechanism (including automatic charges of an account at a financial institution or credit or debit card account) and payment by check” (Medicare Prescription Payment Plan Final Part One Guidance, p. 54). While we acknowledge that these are model materials and may be modified as necessary by sponsors, unless otherwise specified in the guidance, we believe this will ensure clarity for Sponsors that these bullets are not required.

Additionally, in the same exhibit under the header “Can I use this payment option in the future?”, we would recommend revising the header to read, “Can I use the Medicare Prescription Payment Plan in the future?” to delineate between re-enrolling in the program and how participants may think of “payment options” (i.e., payment through mail, credit/debit card, etc.).

Finally, we noted that some required communications, such as the Notice of Denial, did not have a corresponding model document in the PRA posting and was not included in section 30.3 of the Draft Part Two Guidance. We would encourage CMS to develop model documents for all required communications to ensure consistency across sponsors and reduce the potential for participant confusion.

The Honorable Chiquita Brooks-LaSure
Administrator
Centers for Medicare & Medicaid Services
Department of Health and Human Services
7500 Security Blvd
Baltimore, MD 212441

April 29, 2024

Dear Administrator Brooks-LaSure,

Submitted via http://www.regulations.gov

RE: Medicare Prescription Payment Plan Model Documents

The MAPRx Coalition (MAPRx) appreciates the opportunity to provide the Centers for Medicare & Medicaid Services (CMS) with comments regarding the model documents for the implementation of the Medicare Prescription Payment Plan (MPPP) program set to take effect for Contract Year (CY) 2025 per the ***Agency Information Collection Activities: Proposed Collection; Comment Request CMS–10882***, published on February 29, 2024.

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 the request for comments on the MPPP model documents.

MAPRx appreciates the opportunity to continue to comment on how CMS intends to implement and educate beneficiaries on the MPPP, 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 the communication and outreach coming from Part D plans on the MPPP is effective. Specifically, MAPRx would like to focus on the following MPPP model documents:

- **Election approval notice**
- **Election request**
- **Initial notice of failure to pay**
- **Voluntary removal notice**
- **Likely to benefit**
- **Removal for failure to pay**

MAPRx appreciate CMS' effort to require Part D plan sponsors to provide clear MPPP resources that outline the specific action needed to take by prospective, current, or disenrolled participants within the program. Given the complexity of the program and likely confusion among the broader beneficiary population, these tools will serve as critical resources to educate prospective MPPP participants, to help them enroll into the program, and to inform those exiting the program either voluntarily or involuntarily. Overall, MAPRx believes the model documents

are well-developed and generally understandable; however, we offer our thoughts to augment and refine the documents to ensure their effectiveness with the overall beneficiary population.

General content of the model documents
While the content of the model documents may be generally understandable, MAPRx believes the individual documents do not provide a clear, upfront explanation of their respective purposes. As a result, we are concerned that beneficiaries will not fully grasp or understand the action required on their part.

For example, the form "Medicare Prescription Payment Plan participation request form" only contains fields for the beneficiary to complete to opt into the MPPP; it does not provide an easy-to-understand explanation of the form's purpose. The other forms are similarly limited. Providing as much concrete, specific, tailored information as possible will increase the ability of beneficiaries to understand and benefit from the materials.

Lacking information about the MPPP
While each of the model documents serve a specific function, the model documents do not include an upfront, concise overview of the MPPP. Given likely confusion around the new program, MAPRx believes that each document should educate the recipient on the core basics of the program. Without this overview, we are concerned beneficiaries will be confused when receiving one of these documents, especially if they do not receive any MPPP-related documents until later in the year. By including a brief description of the MPPP at the outset of each document, beneficiaries will be able to orient themselves to the purpose of the specific document; thereby better understanding the purpose of the document and the action they may need to take. To further help beneficiaries understand the core concept of the MPPP, we suggest a section title of "Why am I receiving this notice?"

Clearly disclosing the source of the document
As we have mentioned in this comment letter, this new program may cause significant confusion among Part D beneficiaries. To that end, we believe the model documents should clearly state that 1) they originate from the beneficiary's Part D plan sponsor, and 2) the information stems from a new offering from the Medicare program. We are concerned beneficiaries may review the documents and not recognize they were sent by their Part D plans, thereby potentially disregarding the information within the documents.

For example, "Exhibit 3: Part D Sponsor Notice for Failure to Make Payments under Medicare Prescription Payment Plan - Notification of Termination of Participation in the Medicare Prescription Payment Plan" includes a suggested title to introduce the document. We are concerned that Part D plans may fail to disclose the origin of the document. As a result, beneficiaries receiving that document may confuse it with so-called "junk mail" and not give it the required attention it needs, a possibility that is especially concerning given the large amount of Medicare Advantage-related mail that beneficiaries often receive.

We believe that clearly stating the origin of the forms will increase the chance that beneficiaries recognize the importance of the information and, therefore, be more likely to act.

Building more patient protections into the model documents
The patient protections that Congress and CMS embedded in the MPPP are key to program's success. MAPRx believes strongly that the model documents should better highlight the patient protections built into the program; otherwise, we are concerned that beneficiaries may elect to not opt into the program or fail to make a timely payment after receiving a late-payment notice.

MAPRx offers the following patient protections as those that should be more clearly highlighted in the model documents.

- Grace period of at least 2 months if a beneficiary has failed to pay a monthly billed amount
- Part D sponsors must reinstate an individual who has been terminated from the plan if the individual demonstrates good cause for failure to pay their program bill within the grace period and pays all overdue amounts billed
- Appeals process
- Meaningful procedures for the timely hearing and resolution of grievances
- Prohibition from Part D sponsors disenrolling a beneficiary from a Part D plan for failure to pay any amount billed under the Medicare Prescription Payment Plan

Enhancing the information related to the Low-Income Subsidy (LIS)
Several of the model documents conclude the notices with information about other forms of assistance, such as the LIS, the Medicare Savings Program, and State Pharmaceutical Assistance Programs (SPAPs). The Inflation Reduction Act expanded LIS eligibility for the full benefit for those who had traditionally been eligible for only a partial benefit. We believe it would be helpful to let patients know the program expanded in 2024, meaning more people are now eligible. As the population who will benefit from this expansion are not auto-enrolled into the LIS, this may help them understand the benefit has been enhanced and they have to apply in order to receive assistance.

Ensuring accessibility to the model documents
As Part D plan sponsors will send these documents to many beneficiaries, it will be important to ensure the documents are accessible to all Part D beneficiaries. MAPRx respectfully requests CMS to offer the documents in multiple languages to ensure non-English speaking beneficiaries are able to read the content of the documents. Additionally, MAPRx believes that the notices should be available in several different formats—including audio capabilities, Braille, and larger print—for beneficiaries with disabilities.

Implementing a process to consistently incorporate stakeholder feedback
As CY 2025 represents the first year of the new MPPP, there undoubtedly will be many lessons learned. It will be critical for CMS to develop and implement a process to gain stakeholder feedback and incorporate it into future revisions of the model documents. We recommend that CMS explore establishing a process for regular engagement with patients, caregivers, and patient organizations. Additionally, as we mentioned in our comment letter on the Part 2 of the MPPP guidance, we believe CMS should consistently engage State Health Assistance Insurance (SHIP) counselors on these documents as they work with Part D beneficiaries on a daily basis and therefore have visibility into their primary challenges with Part D. Finally, we believe that CMS should facilitate an annual process for revisions to the model documents though a public comment opportunity.

Model document-specific feedback
In addition to the feedback for all of the mode documents, MAPRx offers proposed enhancements to each specific resource.

<u>Likely to benefit notice</u>
Of the six model documents, this resource may be the most important one as it seeks to educate prospective participants on their likelihood to benefit from the program. As mentioned in our comment letter, we believe this document especially should have an overview of the MPPP program. This notice may be the first time a prospective MPPP participant reads about the

program, and it will be critical that they have a foundational understanding of it. We suggest making the benefit of the program clearer to the patient right at the beginning, specifically highlighting the prospective participant will pay monthly installments to spread the expense of their OOP costs out over the number of months remaining in the calendar year (rather than paying them all at once as they have had to do in the past). CMS may also want to consider explaining that monthly installments do not include interest.

In the "How will my costs work with this payment option?" section of the notice, there is language to explain the mechanics of the program. We believe the notice should more clearly explain the impact of not enrolling into the program. We propose adding a sentence similar to this one: "If you do not elect for this new program, you may be responsible for paying up to the annual plan maximum amount of $2,000 at one time if you are prescribed a high-cost medication." An explanation of the maximum out-of-pocket cap would also be helpful to beneficiaries.

Furthermore, for prospective participants to understand the benefit of the MPPP and to envision how it might help them, we suggest including example calculations following the brief overview of the program in this document. Seeing a clear example of how a beneficiary could benefit from the MPPP may increase the likelihood he or she may enroll in the program.

We also recommend that in the "How Do I Know If This Payment Option Might Not be Right for Me" section that language is added to explain why, for example, someone who relies on other forms of prescription drug coverage such as ADAPs, SPAPs or other state programs, charitable assistance, or who receives extra help might not benefit from this program. A beneficiary who receives extra help might think they would especially benefit from the program and would be confused by this section without further explanation.

MPPP election request form

MAPRx appreciates CMS creating a concise form for enrolling into the MPPP that Part D plans must send to beneficiaries most likely to benefit from participating in the MPPP. We approve of CMS' approach in balancing gaining the necessary beneficiary information without being a significant burden to prospective participants. While we believe this form will be effective to facilitate enrollment into the program, we offer several modifications to minimize confusion and for prospective participants to gain a greater understanding of the purpose of the form. We suggest adding a description at the top of the form to remind patients the purpose of the form so they have a clear understanding of the program they are seeking to enroll. We recognize this form will be sent alongside an educational resource on the MPPP; so, while adding this overview may seem unnecessary, the form may get separated from the educational resource, and beneficiaries may therefore set it aside once they have received it in the mail.

Additionally, MAPRx believes it is important for beneficiaries submitting this form to a Part D plan to have a sense of when the enrollment will be finalized by the plan. For example, we suggest adding language outlining the timing by when prospective participants should hear from the plan or when they should contact the plan to inquire about their enrollment status.

MPPP election approval notice

MAPRx appreciates CMS devising a notice to inform participants that they are enrolled in the MPPP. At the beginning of the form, CMS provides this optional text: "Part D sponsors may insert a title for the notice, such as 'You're now participating in the Medicare Prescription Payment Plan'". This is clear language that beneficiaries at all literacy levels are likely to understand, so we believe this sentence should be required. Additionally, the welcome message is fairly sparse;

therefore, we believe there should be additional information to remind newly enrolled participants about the MPPP.

There are several modifications that may be helpful to incorporate into the form. In the "What happens if I don't pay my bill?" section, the form should introduce the grace period and its overall timing of two months. In the "Can I leave the Medicare Prescription Payment Plan?" section, we believe that the language should explicitly state that beneficiaries do not have to pay the remaining balance immediately upon disenrollment. Also, we request that CMS consider adding language that the MPPP does not change from plan to plan, but participants would need enroll through their new plan.

Part D Sponsor Initial Notice for Failure to Make Payments under the Medicare Prescription Payment Plan

Similar to the other documents, MAPRx believes this document should offer a concise overview of the program, given the newness of it. As this notice seeks to inform MPPP participants of a late payment, we recommend that CMS require the Part D plan to send the latest monthly billing statement—which includes information such as total drug costs, dates the prescription(s) were filled, at what pharmacy, patient OOP portion, portion paid by plan, amount remaining in annual $2,000 OOP max—so participants have a clear understanding of their costs and responsibilities.

Additionally, the notice also includes the following instruction to determine the date of the end of the grace period for when a beneficiary fails to make a payment for the MPPP:

> *"…[T]he date that is two calendar months from the first day of the month for which the balance is unpaid or the first day of the month following the date on which the payment is requested, whichever is later."*

We feel beneficiaries may become confused when they receive such a letter. Trying to decipher the explanation of the end of the grace period could be difficult, and it may lead beneficiaries to submit payment on the wrong date or, even worse, become frustrated and abandon the process. Such actions could result in beneficiaries being involuntarily disenrolled from the MPPP. Given this, we believe the Part D plan should clearly state the actual date for the deadline for payment. This deadline should be in large, bolded font so it clearly stands out and the recipient of the notice understands the deadline and implications of failing to pay by that deadline.

We also believe that the language in the second paragraph of the "What Happens if I don't Pay My Bill" section is confusing because it starts off by saying that the beneficiary has to pay their debt, and then continues to say that as long as they pay their premium, they will have drug coverage. This may lead some beneficiaries to confuse the two payments. We would suggest either deleting or rephrasing the first sentence in the paragraph about not paying their debt.

Voluntary removal notice

Similar to the election approval notice, MAPRx requests CMS incorporate language more clearly stating that disenrolling participants do not have to pay the remaining balance all at once. It also may be helpful to include language informing the patient of the amount already applied to their OOP cost calculation if they switch plans.

Similar to our comments about the previous notice, we recommend rephrasing the wording in the "What Happens if I don't pay my balance" section.

Removal for failure to pay notice

MAPRx believes this is a critical resource as it informs beneficiaries they have been involuntarily disenrolled due to failure to pay. We offer several modifications to ensure beneficiary protections are built into place. First, we believe the notice should clearly state that beneficiaries are not being disenrolled from their Part D plan and will only be disenrolled if they fail to make a monthly premium payment. Second, the statement "As of <effective date>, you'll pay the pharmacy directly for all your out-of-pocket drug costs." might confuse disenrolled participants into thinking they have to pay 100% in OOP costs without any coverage from their plan. Therefore, we suggest making it clear that they would have to pay the pharmacy for their OOP share of cost after the plan pays its share.

Feedback on Part 2 guidance

MAPRx appreciates CMS' guidance to Part D plan sponsors on education and outreach and the agency's own effort to do so directly to Part D beneficiaries. While these model documents will be important for the success of beneficiary participation in the MPPP, we believe it is important to reiterate our thoughts from the Part 2 guidance:

- Require plan sponsors to include MPPP information and the election mechanism prominently on their Medicare websites to ensure the greatest number of beneficiaries view the information
- Require Part D plans to ensure the election mechanism on plan websites is easy to navigate, certainly no more difficult than enrolling in the plan
- Adopt a standardized auditing process of the MPPP, which would promote consistency of reviews and also provide Part D sponsors with a clear example of implementing and administering an effective MPPP
- Require plans submit information on their MPPP and associated compliance approach in annual plan bid submissions so that the agency can proactively review them in advance of the upcoming plan year
- Establish the threshold for targeted outreach to be based on cumulative costs, not a cost threshold for a single prescription
- Ensure that MPPP promotional and educational materials are as easy as possible for beneficiaries to understand
- Offer a clear enrollment mechanism on the Plan Finder website, similar to mechanism used to enroll into a Part D plan today
- Produce and deploy public service announcements from Medicare at waiting rooms at healthcare facilities such as physician offices, federally qualified health centers, etc.
- Offer a POS be an option as soon as possible, but no later than CY 2026

Conclusion

Thank you for your consideration of our comments on the MPPP model documents. The undersigned members of MAPRx appreciate your leadership to improve beneficiary 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
HIV+Hepatitis Policy Institute
International Myeloma Foundation
Lakeshore Foundation
LUNGevity Foundation
Lupus and Allied Diseases Association, Inc.
Lupus Foundation of America
Mental Health America
Muscular Dystrophy Association
National Alliance on Mental Illness (NAMI)
National Council for Mental Wellbeing
National Council on Aging
National Health Council
National Kidney Foundation
National Organization for Rare Disorders
National Psoriasis Foundation
Patient Access Network (PAN) Foundation
The AIDS Institute
The Assistance Fund
The Leukemia & Lymphoma Society
Triage Cancer

Exhibit 1 – Part D Sponsor Notice to Acknowledge Acceptance of Election in the Medicare Prescription Payment Plan

Referenced in [insert draft part 2 guidance section]

<Part D sponsors may insert a title for the notice, such as "You're now participating in the Medicare Prescription Payment Plan">

<Member #>

<RxID>

<RxGroup>

<RxBin>

<RxPCN>

<Date>

Dear <Name of Member>,

Welcome to the Medicare Prescription Payment Plan, a payment option that works with your <plan name>. Your participation starts on <insert date>.

What happens now?

1. We'll let your pharmacy (including mail-order and specialty pharmacies) know that you're using this payment option.
2. When you fill a prescription for a drug covered by Part D, you won't pay your pharmacy for the prescription.
3. Each month <plan name> will send you a bill with the amount you owe, when it's due, and information on how to make a payment. You'll get a separate bill for your monthly plan premium (if you have one).

How is my monthly bill calculated?

Your monthly bill is based on what you owe for any prescriptions you get, plus your previous month's balance, divided by the number of months left in the year.

Your payments might change every month, so you might not know what your exact bill will be ahead of time. Future payments might increase when you fill a new prescription or refill an existing prescription because as new out-of-pocket costs are added into your monthly payment, there are fewer months left in the year to spread out your payments. You'll never pay any interest or fees on the amount you owe, even if your payment is late.

Remember, in a single calendar year (Jan – Dec), you'll never pay more than:

- The total amount you would have paid out of pocket to the pharmacy.
- The Medicare drug coverage annual out-of-pocket maximum (which is $2,000 in 2025).

What happens if I don't pay my bill?

We'll send you a reminder if you miss a payment. If you don't pay your bill by the date listed in that reminder, you'll be removed from the Medicare Prescription Payment Plan. Like any other debt, you're

quired to pay the amount you owe. Always pay your <plan name> premium first (if you have one), so you don't lose your drug coverage.

If you think that we've made a mistake with the amount you owe, call us at <phone number>. You also have the right to follow the grievance process found in your <insert "Member Handbook" or "Evidence of Coverage," as appropriate>.

Can I leave the Medicare Prescription Payment Plan?

You can leave the Medicare Prescription Payment Plan at any time by calling us at <phone number>. If you still owe a balance, you're required to pay the amount you owe, even though you're no longer participating in the program. You can choose to pay the remaining amount all at once or be billed monthly. If you leave, your Medicare drug coverage and other Medicare benefits won't be affected, and you'll go back to paying the pharmacy directly for all your out-of-pocket drug costs.

If you leave <current plan name> or change to a new Medicare drug plan or Medicare health plan with drug coverage (like a Medicare Advantage Plan) your participation in the Medicare Prescription Payment Plan will end. If you change plans, and you'd like to join the Medicare Prescription Payment Plan offered through your new plan, contact your new plan.

Are there programs that can help lower my costs?

While the Medicare Prescription Payment Plan spreads out your costs, it doesn't lower them. However, you may be eligible for programs that can help lower your costs, like:

- **Extra Help:** A Medicare program that helps pay your Medicare drug costs if you have limited income and resources. Visit secure.ssa.gov/i1020/start to find out if you qualify and apply. You can also apply with your state's Medicaid office. Visit Medicare.gov/basics/costs/help/drug-costs to learn more.
- **Medicare Savings Program**: A state-run program that helps people with limited income and resources pay some or all of their Medicare premiums, deductibles, and coinsurance. Visit Medicare.gov/medicare-savings-programs to learn more.
- **State Pharmaceutical Assistance Program (SPAP):** A program that may include coverage for your Medicare drug plan premiums and/or cost sharing. SPAP contributions may count toward your Medicare drug coverage out-of-pocket limit. Visit go.medicare.gov/spap to learn more.
- **Manufacturer's Pharmaceutical Assistance Programs** (sometimes called Patient Assistance Programs (PAPs)): A program from drug manufacturers to help lower drugs costs for people with Medicare. Visit go.medicare.gov/pap to learn more.

Many people qualify for savings and don't realize it. Visit Medicare.gov/basics/costs/help, or contact your local Social Security office to learn more. Find your local Social Security office at secure.ssa.gov/ICON/main.jsp or call 1-800-772-1213. TTY users can call 1-800-325-0778.

Medicare Prescription Payment Plan participation request form

FIRST name: LAST name: MIDDLE initial (optional):

Medicare Number: _ _ _ _ - _ _ _ - _ _ _ _

Birth date: (MM/DD/YYYY) (/ /)

Phone number: ( )

Permanent residence street address (don't enter a P.O. Box unless you're experiencing homelessness):

City: County (optional): State: ZIP code:

Mailing address, if different from your permanent address (P.O. Box allowed):
Address: City: State: ZIP code:

Do you get help paying your prescription drug costs from a program like Medicare's Extra Help, a State Pharmaceutical Assistance Program (SPAP), Indian Health Services, or other health insurance?
☐ Yes ☐ No ☐ Not sure

- I understand this form is a request to participate in the Medicare Prescription Payment Plan. <Plan Name> will contact me if they need more information.
- I understand that signing this form means that I've read and understand the form <and the attached terms and conditions (if included)>.
- **<Plan Name> will send me a notice to let me know when my participation in the Medicare Prescription Payment Plan is active.** Until then, I understand that I'm not a participant in the Medicare Prescription Payment Plan.

Signature: **Date:**

Name: Address (Street, City, State, ZIP code):

Phone number: ( ) Relationship to participant:

How to submit this form

Submit your completed form to:

<Plan Name>
<Plan address>
<Plan address>
<Plan address>
<Plan fax number if applicable>
<Plan email if plan chooses to accept forms via email>

<Plans can insert their Medicare Prescription Payment Plans terms and conditions on the back of this form or attach them separately>

Exhibit 2 – Part D Sponsor Initial Notice for Failure to Make Payments under the Medicare Prescription Payment Plan

Referenced in [insert draft part 2 guidance section]

<Part D sponsors may insert a title for the notice, such as "Urgent: Pay your Medicare Prescription Payment Plan bill">

<Member #>

<RxID>

<RxGroup>

<RxBin>

<RxPCN>

Dear < Member>:

We didn't get your monthly payment for the Medicare Prescription Payment Plan that was due <insert payment due date>. To stay in the Medicare Prescription Payment Plan, you must pay <insert the full amount or a partial amount(s) should the plan choose to allow enrollees to pay the balance over separate payments> by <insert date for the end of the grace period (i.e., the date that is two calendar months from the first day of the month for which the balance is unpaid or the first day of the month following the date on which the payment is requested, whichever is later)>.

This letter only applies to your participation in the Medicare Prescription Payment Plan. Your Medicare drug coverage and other Medicare benefits won't be affected, and you'll continue to be enrolled in <plan name> for your drug coverage.

How do I pay my bill?

You can choose to pay the amount you owe all at once or be billed monthly. You'll never pay any interest or fees on the amount you owe.

You owe <insert unpaid>. You can pay:

- Online at <plan's website>, by credit/debit card.
- Through the mail, by check.
- <insert other payment methods offered by the plan like electronic funds transfer (including automatic charges of an account at a financial institution or credit or debit card account)>.

If you have questions about your payment, call us at <phone number>, <days and hours of operation>. TTY users can call < TTY number>.

What happens if I don't pay my bill?

If you don't pay your bill by <insert effective date>, you'll no longer be in the Medicare Prescription Payment Plan through <plan sponsor>. As of <effective date>, you'll pay the pharmacy directly for your out-of-pocket drug costs.

Like any other debt, you're required to pay the amount you owe. As long as you continue to pay your plan premium (if you have one), you'll still have drug coverage through <plan name>.

What if I think there's been a mistake?

If you think that we've made a mistake, call us at <phone number>. You also have the right to ask us to reconsider our decision through a grievance process. Check your <insert "Member Handbook" or "Evidence of Coverage," as appropriate>.

What if I can't afford to pay both my plan premium and my Medicare Prescription Payment Plan payment?

Always pay your <plan name> premium first (if you have one). If needed, we can apply a payment you've made toward your **Medicare Prescription Payment Plan** balance to your plan premium instead. Call us at <phone number> to discuss this option.

Are there programs that can help lower my costs?

While the Medicare Prescription Payment Plan spreads out your costs, it doesn't lower them. However, you may be eligible for programs that can help lower your costs, like:

- **Extra Help:** A Medicare program that helps pay your Medicare drug costs if you have limited income and resources. Visit secure.ssa.gov/i1020/start to find out if you qualify and apply. You can also apply with your state's Medicaid office. Visit Medicare.gov/basics/costs/help/drug-costs to learn more.
- **Medicare Savings Program**: A state-run program that helps people with limited income and resources pay some or all of their Medicare premiums, deductibles, and coinsurance. Visit Medicare.gov/medicare-savings-programs to learn more.
- **State Pharmaceutical Assistance Program (SPAP):** A program that may include coverage for your Medicare drug plan premiums and/or cost sharing. SPAP contributions may count toward your Medicare drug coverage out-of-pocket limit. Visit go.medicare.gov/spap to learn more.
- **Manufacturer's Pharmaceutical Assistance Programs** (sometimes called Patient Assistance Programs (PAPs)): A program from drug manufacturers to help lower drugs costs for people with Medicare. Visit go.medicare.gov/pap to learn more.

Many people qualify for savings and don't realize it. Visit Medicare.gov/basics/costs/help, or contact your local Social Security office to learn more. Find your local Social Security office at secure.ssa.gov/ICON/main.jsp or call 1-800-772-1213. TTY users can call 1-800-325-0778.

Note: The programs listed above can help lower your costs, but they can't help you pay off your Medicare Prescription Payment Plan balance.

Consider Managing Your Monthly Drug Costs with the Medicare Prescription Payment Plan

You might benefit from participating in the Medicare Prescription Payment Plan, because you have high drug costs. This new payment option works with your current drug coverage, and it can help you manage your drug costs by spreading them across **monthly payments that vary throughout the year** (January – December).

What's the Medicare Prescription Payment Plan?

The Medicare Prescription Payment Plan is a new payment option to help you manage your out-of-pocket drug costs, starting in 2025. All Medicare drug plans and Medicare health plans with drug coverage (like a Medicare Advantage Plan) must offer this payment option, and all plans use the same formula to calculate your monthly payments. If you select this payment option, each month you'll pay your plan premium (if you have one) and you'll get a bill from your health or drug plan for your prescription drugs (instead of paying the pharmacy).

Participating in this payment option is voluntary. Anyone with a Medicare drug plan or a Medicare health plan with drug coverage can use this payment option, which applies to all prescription drugs covered by Part D. It doesn't cost anything to participate in the Medicare Prescription Payment Plan, and you won't pay any interest or fees on the amount you owe, even if your payment is late.

Will this payment option help me?

It depends on your situation. If you have high out-of-pocket drug costs, this payment option spreads out what you'll pay each month across the year (January – December), so you don't have to pay out-of-pocket costs to the pharmacy. **This payment option might help you manage your expenses, but it doesn't save you money or lower your drug costs.** Visit Medicare.gov/basics/costs/help/drug-costs to learn about programs that can help lower your drug costs.

How will my costs work with this payment option?

The new prescription drug law caps your out-of-pocket costs at $2,000 in 2025 and eliminates the coverage gap (known as the "donut hole"). This means you'll never pay more than $2,000 in out-of-pocket drug costs in 2025. **This is true for everyone with Medicare drug coverage, even if you don't join the Medicare Prescription Payment Plan.**

When you fill a prescription for a drug covered by Part D, you won't pay your pharmacy (including mail-order and specialty pharmacies). Instead, you'll get a bill each month from your plan. Your monthly bill is based on what you owe for any prescriptions you get, plus your previous month's balance, divided by the number of months left in the year.

Note: Your payments might change every month, so you might not know what your exact bill will be ahead of time. Future payments might increase when you fill a new prescription or refill an existing prescription because as new out-of-pocket drug costs are added into your monthly payment, there are fewer months left in the year to spread out your payments.

How do I know if this payment option might not be right for me?

This payment option might not be helpful for you if:

- You get Extra Help from Medicare.
- You qualify for a Medicare Savings Program.

You get help paying for your drugs from other organizations, like a State Pharmaceutical Assistance Program (SPAP) or other health coverage.

- Your yearly drug costs are low.
- Your drug costs are the same each month.
- You're considering signing up for the payment option late in the calendar year (after September).
- You don't want to change how you pay for your drugs.

Who can help me decide if I should sign up for this payment option?

- **Your plan:** Visit your plan's website, or call your plan to get more information. Your plan's phone number is on the back of your membership card.
- **Medicare:** Visit Medicare.gov/tbd, or call 1-800-MEDICARE (1-800- 633-4227), 24 hours a day, 7 days a week. TTY users can call 1-877-486-2048.
- **State Health Insurance Program (SHIP):** Visit shiphelp.org to get the phone number for your local SHIP and get free, personalized health insurance counseling.

How do I sign up for this payment option?

To sign up for this payment option, visit your plan's website or call your plan. You can find your plan's phone number on the back of your membership card. If you need to pick up a prescription urgently, the fastest way to use this payment option is to call your plan.

Need this information in another format or language?

To get this material in other formats like large print, braille, or another language, contact your Medicare drug plan. If you need help contacting your plan, call: 1-800-MEDICARE (1-800-633-4227).

Exhibit 3 - Part D Sponsor Notice for Failure to Make Payments under Medicare Prescription Payment Plan - Notification of Termination of Participation in the Medicare Prescription Payment Plan

Referenced in [insert draft part 2 guidance section]

<Part D sponsors may insert a title for the notice, such as "Important: Your participation in the Medicare Prescription Payment Plan has ended">

<Member #>

<RxID>

<RxGroup>

<RxBin>

<RxPCN>

<Date>

Dear < Member>,

On <date of initial notification of failure to pay>, we sent you a letter letting you know your monthly payment for the Medicare Prescription Payment Plan was overdue. The letter explained that if you didn't make your payment by <insert time frame>, we'd end your participation in the Medicare Prescription Payment Plan.

Starting <insert effective date, which should be the same date as this letter>, you're no longer participating in the Medicare Prescription Payment Plan through <plan sponsor> because we didn't get your monthly payment. Like any other debt, you're still required to pay the amount you owe, $<amount owed>.

As of <effective date>, you'll pay the pharmacy directly for all your out-of-pocket drug costs.

This letter only applies to your participation in the Medicare Prescription Payment Plan. Your Medicare drug coverage and other Medicare benefits won't be affected, and you'll continue to be enrolled in <plan name> for your drug coverage.

How do I pay my balance?

You can choose to pay the amount you owe all at once or be billed monthly. You'll never pay any interest or fees on the amount you owe.

You owe <insert unpaid>. You can pay:

- Online at <plan's website>, by credit or debit card.
- Through the mail, by check.
- <insert other payment methods offered by the plan sponsor like electronic funds transfer (including automatic charges of an account at a financial institution or credit or debit card account)>.

If you have questions about your payment, call us at <phone number>, <days and hours of operation>. TTY users can call <TTY number>.

What if I think there's been a mistake?

If you think that we've made a mistake, call us at <phone number>. You also have the right to ask us to reconsider our decision through the grievance process in your <insert "Member Handbook" or "Evidence of Coverage," as appropriate>.

Can I use this payment option in the future?

Yes, once you pay the total amount you owe.

Are there programs that can help lower my costs?

You may be eligible for programs that can help lower your costs, like:

- **Extra Help:** A Medicare program that helps pay your Medicare drug costs if you have limited income and resources. Visit secure.ssa.gov/i1020/start to find out if you qualify and apply. You can also apply with your state's Medicaid office. Visit Medicare.gov/basics/costs/help/drug-costs to learn more.
- **Medicare Savings Program**: A state-run program that helps people with limited income and resources pay some or all of their Medicare premiums, deductibles, and coinsurance. Visit Medicare.gov/medicare-savings-programs to learn more.
- **State Pharmaceutical Assistance Program (SPAP):** A program that may include coverage for your Medicare drug plan premiums and/or cost sharing. SPAP contributions may count toward your Medicare drug coverage out-of-pocket limit. Visit go.medicare.gov/spap to learn more.
- **Manufacturer's Pharmaceutical Assistance Programs** (sometimes called Patient Assistance Programs (PAPs)): A program from drug manufacturers to help lower drugs costs for people with Medicare. Visit go.medicare.gov/pap to learn more.

Many people qualify for savings and don't realize it. Visit Medicare.gov/basics/costs/help, or contact your local Social Security office to learn more. Find your local Social Security office at secure.ssa.gov/ICON/main.jsp or call 1-800-772-1213. TTY users can call 1-800-325-0778.

Note: The programs listed above can help lower your costs, but they can't help you pay off your Medicare Prescription Payment Plan balance.

Exhibit 4 - Part D Sponsor Notification of Voluntary Removal from the Medicare Prescription Payment Plan

Referenced in [insert draft part 2 guidance section]

<Part D sponsors may insert a title for the notice, such as "You're no longer participating in the Medicare Prescription Payment Plan through <plan sponsor>">

<Member #>

<RxID>

<RxGroup>

<RxBin>

<RxPCN>

Dear <Member>,

Starting <insert effective date>, you're no longer participating in the Medicare Prescription Payment Plan through <plan sponsor>. As of <effective date>, you'll pay the pharmacy directly for your out-of-pocket drug costs.

You're getting this letter because you either asked to stop participating in this payment option, **or** you changed your Medicare drug plan or Medicare health plan with drug coverage (like a Medicare Advantage Plan). If you changed plans, and you'd like to join the Medicare Prescription Payment Plan offered through your new plan, contact your new plan.

This letter only applies to your participation in the Medicare Prescription Payment Plan. Your Medicare drug coverage and other Medicare benefits won't be affected, and you'll continue to be enrolled in <plan name> for your drug coverage.

How do I pay my balance?

You can choose to pay the amount you owe all at once or be billed monthly. You'll never pay any interest or fees on the amount you owe, even if your payment is late.

You owe <insert unpaid>. You can pay:

- Online at <plan's website>, by credit or debit card.
- Through the mail, by check.
- <insert other payment methods offered by the plan sponsor like electronic funds transfer (including automatic charges of an account at a financial institution or credit or debit card account)>.

If you have questions about your payment, call us at <phone number>, <days and hours of operation>. TTY users can call <TTY number>.

What happens if I don't pay my balance?

Like any other debt, you're required to pay the amount you owe. As long as you continue to pay your plan premium (if you have one), you'll still have drug coverage.

Can I use this payment option in the future?

- **If you're still in <plan name>:** Yes. Visit <insert PDP webpage where the application is>, or call us at <phone number> <days and hours of operation>. TTY users can call <TTY number>.
- **If you're joining a new plan:** Yes. All Medicare drug plans and Medicare health plans with drug coverage must offer this payment option. No matter what Medicare drug plan you're in, you can choose to rejoin the Medicare Prescription Payment Plan at any time.

Are there programs that can help lower my costs?

You may be eligible for programs that can help lower your costs, like:

- **Extra Help:** A Medicare program that helps pay your Medicare drug costs if you have limited income and resources. Visit secure.ssa.gov/i1020/start to find out if you qualify and apply. You can also apply with your state's Medicaid office. Visit Medicare.gov/basics/costs/help/drug-costs to learn more.
- **Medicare Savings Program**: A state-run program that helps people with limited income and resources pay some or all of their Medicare premiums, deductibles, and coinsurance. Visit Medicare.gov/medicare-savings-programs to learn more.
- **State Pharmaceutical Assistance Program (SPAP):** A program that may include coverage for your Medicare drug plan premiums and/or cost sharing. SPAP contributions may count toward your Medicare drug coverage out-of-pocket limit. Visit go.medicare.gov/spap to learn more.
- **Manufacturer's Pharmaceutical Assistance Programs** (sometimes called Patient Assistance Programs (PAPs)): A program from drug manufacturers to help lower drugs costs for people with Medicare. Visit go.medicare.gov/pap to learn more.

Many people qualify for savings and don't realize it. Visit Medicare.gov/basics/costs/help, or contact your local Social Security office to learn more. Find your local Social Security office at secure.ssa.gov/ICON/main.jsp or call 1-800-772-1213. TTY users can call 1-800-325-0778.

Note: The programs listed above can help lower your costs, but they can't help you pay off your Medicare Prescription Payment Plan balance.

MEDICARE RIGHTS CENTER
Getting Medicare right

266 West 37th Street, 3rd Floor
New York, NY 10018
212.869.3850/Fax: 212.869.3532

April 29, 2024

VIA ELECTRONIC SUBMISSION

Centers for Medicare & Medicaid Services
Office of Strategic Operations and Regulatory Affairs
Division of Regulations Development
Baltimore, Maryland 21244–1850

Re: The Medicare Advantage and Prescription Drug Programs: Part C and Part D Medicare Prescription Payment Plan Model Documents (CMS-10882)

The Medicare Rights Center (Medicare Rights) appreciates this opportunity to comment on the **The Medicare Advantage and Prescription Drug Programs: Part C and Part D Medicare Prescription Payment Plan Model Documents (CMS-10882)**. Medicare Rights is a national, nonprofit organization that works to ensure access to affordable and equitable health care for older adults and people with disabilities through counseling and advocacy, educational programs, and public policy initiatives. Each year, Medicare Rights provides services and resources to over three million people with Medicare, family caregivers, and professionals.

The Inflation Reduction Act's Medicare Prescription Payment Plan (MPPP) provides an opportunity to decrease burdens on people with Medicare by allowing them to spread out high prescription drug costs over months instead of having to pay a significant portion of the annual out-of-pocket maximum in a single trip to the pharmacy. That said, we believe this program will be a source of considerable confusion as beneficiaries, providers, plans, and pharmacies attempt to navigate its many complexities.

We thank you for soliciting these comments and for your work incorporating earlier comments on the MPPP's implementation from Medicare Rights, other advocates, and stakeholders in general. While the MPPP's complexity will inevitably lead to snags, we believe these documents will help alert beneficiaries to the information they need and best position the program for success.

Thank you again for the opportunity to provide comment. For additional information, please contact Lindsey Copeland, Federal Policy Director at LCopeland@medicarerights.org or 202-637-0961 and Julie Carter, Counsel for Federal Policy at JCarter@medicarerights.org or 202-637-0962.

Sincerely,

Lindsey Copeland
Director of
Federal Policy Director
Medicare Rights Center

NATIONAL HEALTH COUNCIL

April 29, 2024

Chiquita Brooks-LaSure
Administrator
Centers for Medicare & Medicaid Services
Department of Health and Human Services
7500 Security Boulevard
Baltimore, MD 21244

RE: The Medicare Advantage and Prescription Drug Programs: Part C and Part D Medicare Prescription Payment Plan Model Documents (CMS-10882)

Dear Administrator Brooks-LaSure:

The National Health Council (NHC) appreciates the opportunity to provide comments to the Centers for Medicare & Medicaid Services (CMS) in response to the Medicare Advantage and Prescription Drug Programs: Part C and Part D Medicare Prescription Payment Plan Model Documents information collection request (ICR).

Created by and for patient organizations over 100 years ago, the NHC brings diverse organizations together to forge consensus and drive patient-centered health policy. We promote increased access to affordable, high-value, equitable, and sustainable health care. Made up of more than 170 national health-related organizations and businesses, the NHC's core membership includes the nation's leading patient organizations. Other members include health-related associations and nonprofit organizations including the provider, research, and family caregiver communities; and businesses and organizations representing biopharmaceuticals, devices, diagnostics, generics, and payers.

General Comments

The NHC values CMS's initiatives to enhance the Medicare Prescription Drug Program (Part D) with the out-of-pocket maximum and the Medicare Prescription Payment Plan (MPPP), including through the creation of six model documents aimed at helping Part D sponsors and Medicare Advantage (MA) insurance plans in adhering to new regulatory requirements. Recognizing both the potential benefits and challenges of the MPPP rollout, the NHC views the introduction of these documents as crucial for educating beneficiaries on their options, easing transitions, and possibly lessening the financial impact of prescription costs. While we find these documents generally well-constructed and accessible, there are opportunities for improvement to ensure they fully convey the MPPP's intricacies to all beneficiaries.

The NHC commends CMS for its work in making these materials understandable – a vital component of beneficiary communication and education. However, to amplify their effectiveness, it is essential for CMS to engage more deeply with patient organizations,

including the NHC, on your outreach and engagement strategy and messaging. Such collaboration is key to refining the documents and other strategies to not only meet regulatory standards but to also genuinely reflect the needs and experiences of beneficiaries, ultimately boosting their understanding and participation in the MPPP. The following guiding principles and core recommendations emerged from the NHC's analysis of the model documents:

- **Enhancing Accessibility and Understanding**
  - **Plain Language Use**: We recommend the utilization of plain language across all model documents to ensure they are comprehensible for a broad audience, including individuals with limited health literacy.
  - **Multi-language Availability**: We emphasize the necessity of translating documents and adapting content culturally to meet the needs of non-English speaking beneficiaries, thereby enhancing their understanding and engagement with the MPPP.
  - **Disability Consideration**: We highlight the importance of making documents accessible in formats that accommodate beneficiaries with disabilities, including Braille, large print, audio formats, and ensuring compatibility with screen readers.
- **Beneficiary Engagement and Education**
  - **Direct Engagement**: We recommend establishing a collaborative process that involves beneficiaries and patient organizations in the review and feedback process to ensure materials address real concerns and circumstances.
  - **Educational Outreach**: We suggest the development of supplementary educational resources, such as cost calculators or decision aids, to provide beneficiaries with personalized insights into the financial implications of the MPPP.
  - **Stakeholder Collaboration**: We recommend collaboration with State-based pharmacy associations to enhance educational materials, ensuring they address specific beneficiary needs at the point of service.
- **Continuous Feedback and Improvement**
  - **Feedback Mechanism**: We recommend the creation of a structured feedback loop with stakeholders to gather insights and concerns, enabling timely updates and revisions to the documents.
  - **Periodic Reviews**: We suggest conducting periodic reviews of the MPPP's impact based on quantitative data and qualitative feedback to inform targeted improvements.
- **Communication and Transparency**
  - **Clear Communication**: We emphasize the need for documents to clearly and effectively communicate the nuances of the MPPP to beneficiaries, aiding in their decision-making process.
  - **Fraud Prevention**: We advise incorporating detailed examples within materials to help beneficiaries recognize official correspondence and understand billing statements, thereby preventing potential fraud.

- **Public Awareness**
  - **Awareness Campaigns**: We suggest partnering with the patient community for public awareness campaigns to maximize knowledge and participation in the MPPP.

As the health care landscape continues to evolve, the NHC remains dedicated to ensuring that policies and programs like the MPPP are implemented in a manner that prioritizes the needs of patients. While the initiative to develop these model documents is a step in the right direction, continuous monitoring, feedback, and adjustments will be essential to address the challenges and barriers beneficiaries may face in accessing and understanding their health care options. The NHC is committed to working alongside CMS and other stakeholders to ensure that the MPPP serves the best interests of Medicare beneficiaries, particularly those with chronic conditions and disabilities, fostering a more inclusive and equitable health care system. To that end, the NHC offers the following comments.

Emphasis on Beneficiary Engagement

In the deployment of the MPPP and its accompanying model documents, the NHC underscores the importance of direct beneficiary engagement and the involvement of patient organizations in the review and feedback process. This approach is essential to ensure that the documents comprehensively address the real concerns, questions, and circumstances faced by Medicare beneficiaries, particularly those navigating chronic diseases and disabilities. The NHC strongly recommends CMS implement a continuous and collaborative process wherein beneficiaries, patient organizations, and other key stakeholders such as pharmacy entities play a critical role in shaping and disseminating communications to make them more relevant, accessible, and effective.

Engaging beneficiaries and incorporating their feedback and experiences directly into the MPPP's communication strategy are critical to ensuring the program not only meets regulatory standards but effectively addresses the needs of its intended audience. This approach is about more than just enhancing health literacy; rather, it is about making new policy changes clear and accessible to all, especially to older populations who may not engage with digital platforms extensively. These beneficiaries often rely on more traditional forms of communication, like direct interactions with pharmacy technicians, pharmacists, or designated navigators or through paper inserts included in plan mailings. Recognizing this, the NHC emphasizes the need to develop a comprehensive communications strategy that utilizes multiple channels to reach all beneficiaries, ensuring that everyone, regardless of their familiarity with technology or preferred method of receiving information, has access to and can understand the information about the MPPP. By prioritizing such inclusivity, CMS can better fulfill its mission to deliver support and information to all beneficiaries.

Importance of Broad Educational Outreach

The educational and outreach components of the MPPP model documents are crucial to ensure that Medicare beneficiaries fully understand how to navigate the program, appreciate the benefits it offers, and understand the implications of non-payment. Clear,

concise, and accessible materials are fundamental in empowering beneficiaries to navigate the complexities of prescription drug costs under the MPPP.

However, given CMS's primary focus on providing specific materials to those deemed "likely to benefit," we continue to stress the importance of outreach, education, and availability of tools that is as broad as possible in addition to targeted outreach, including through model documents.

In addition to the foundational materials provided, the NHC strongly advocates for the development of **supplementary educational resources, such as cost calculators or decision aids,** that can be integrated with the model documents. These tools, designed with a patient-centered approach, would serve as invaluable assets for beneficiaries, enabling them to visualize the financial implications of participating in the MPPP and to assess how the program aligns with their individual health care needs and financial circumstances. The creation of interactive tools and decision aids acknowledges the diverse needs and preferences of Medicare beneficiaries, ensuring that all beneficiaries, including those with limited English proficiency or disabilities, can benefit from the. By providing personalized insights into potential out-of-pocket costs and savings, these resources would help demystify the program's benefits and encourage more beneficiaries to take advantage of the MPPP's offerings.

Additionally, the MPPP model documents present an excellent opportunity to inform beneficiaries about other significant benefits under Medicare Part D, which may not be widely known. For example, the elimination of copays for recommended vaccines and the introduction of a $35 monthly cap on covered insulin products are substantial benefits that can aid in managing health care costs and improving health outcomes. The NHC suggests that these benefits be succinctly highlighted within the model documents, potentially in a dedicated subsection that outlines additional resources and benefits available under Medicare Part D. This approach will not only educate beneficiaries about the full spectrum of their coverage but also encourage the utilization of preventative care measures and chronic disease management tools available through Medicare.

The NHC encourages CMS to extend its efforts beyond model documents by collaborating with the patient community to initiate general public awareness campaigns, ensuring widespread knowledge of the program. It is vital to ensure that all Medicare beneficiaries, including those not currently burdened by high prescription drug costs, understand the MPPP's benefits. Given that beneficiaries' health care needs and financial circumstances can evolve, early education about the MPPP's scope and potential benefits is essential. Incorporating a comprehensive overview of the MPPP, explaining its origins, objectives, and long-term benefits, into this educational strategy can ensure that all beneficiaries, regardless of their current medication costs, recognize its value. This approach, complemented by practical tools, will not only foster a more informed beneficiary base but also strengthens community support for and confidence in the Medicare system by addressing the varying needs and circumstances across the beneficiary spectrum. The NHC believes that CMS can, through this comprehensive approach, significantly boost the efficacy of its educational outreach efforts, leading to higher program uptake and satisfaction among beneficiaries.

The NHC recognizes the multifaceted approach needed to effectively educate and engage Medicare beneficiaries about the MPPP. Beyond developing supplementary educational tools and ensuring the comprehensiveness of outreach materials, there is a crucial need for targeted, direct engagement at the point of care. To this end, collaboration with State-based pharmacy associations, leveraging their deep understanding of pharmacy consumerism and the intricacies of pharmacy networks across various states, is essential. This partnership could significantly enhance the educational materials by ensuring they address the specific needs and questions of beneficiaries at the point of service in pharmacies. Such a proactive approach would not only educate pharmacy staff on the nuances of the new policy but also ensure that Medicare consumers are not inappropriately charged or turned away due to misunderstandings about coverage. By integrating the expertise of these associations, the NHC aims to bridge any knowledge gaps and fortify the support system for beneficiaries, thereby enhancing their understanding and engagement with the program and ultimately facilitating a smoother and more informed enrollment process.

Simultaneously, the critical role of local engagement in disseminating information about the MPPP cannot be overstated. By mobilizing networks of Community Health Workers or Health Navigators who collaborate with Community-Based Organizations (CBOs) or Federally Qualified Health Centers (FQHCs), CMS can extend the reach and enhance the effectiveness of the program's messaging, ensuring that it resonates at the community level and reaches consumers who may benefit most. This grassroots approach to education and outreach promises to amplify the impact of the MPPP, fostering a more inclusive and informed beneficiary community.

Enhancing MPPP Documents with FAQs and Real-life Scenarios

To further enhance the clarity and usefulness of the model documents for the MPPP, the NHC suggests that these materials incorporate real-life scenarios and Frequently Asked Questions (FAQs) that reflect the diverse experiences of Medicare beneficiaries. Such content could significantly improve beneficiaries' understanding of the MPPP by providing actionable insights into how the program might affect their prescription drug costs and overall health management. The NHC recommends that all model documents include examples that clearly illustrate how beneficiaries with varying prescription needs could see tangible benefits from enrolling in the MPPP. Such practical demonstrations will simplify complex information and make the benefits of the MPPP more tangible and understandable for all beneficiaries. Moreover, incorporating real-life scenarios provides a relatable context that helps bridge the gap between policy language and the lived experiences of patients, fostering a deeper connection with the program and aids in the comprehension of its features and benefits. FAQs should address common questions and concerns, potentially minimizing confusion and simplifying the process for beneficiaries to find the information they need. To ensure these materials meet the evolving needs of beneficiaries, the NHC recommends that CMS actively engage with a broad spectrum of stakeholders, including Medicare beneficiaries, Part D sponsors, health care providers, and patient organizations. By maintaining a continuous dialogue with these groups, CMS can finely tune the materials to address specific concerns, leading to more effective communications. This ongoing conversation will allow for a dynamic and flexible approach to updating and revising the documents as needed, ensuring the MPPP remains relevant and effectively supports its users.

These enhancements, aimed at incorporating the lived experiences of patients into the MPPP documentation, go beyond merely improving the readability of the materials. They are a critical step towards building trust and transparency between beneficiaries, patient organizations, and health care administrators. By making these modifications, the NHC aims to deepen beneficiary engagement with the MPPP, ensuring that all Medicare recipients have the necessary knowledge and resources to effectively navigate their health care options.

Recommendations for Document Clarity and Accessibility

In advancing the MPPP and ensuring its successful implementation, particular attention must be given to the clarity and accessibility of all associated model documents. The NHC strongly recommends that CMS prioritize the use of plain language in these materials. This approach will facilitate a broader understanding among beneficiaries, catering to the diverse spectrum of individuals the program aims to serve, including those with limited English proficiency (LEP) and disabilities. The essence of clear communication lies not only in simplifying complex legal and health care jargon but also in ensuring that information is direct, engaging, and easily navigable.

It is imperative that these documents are made available in multiple languages and formats, aligning with the inclusivity and accessibility standards set forth in the 2024 Medicare Advantage and Part D Final Rule.[1] This commitment to diversity and accessibility should extend beyond the mere translation of text to include the thoughtful adaptation of content to meet the cultural and contextual needs of non-English speaking beneficiaries. For example, this could involve the creation of culturally tailored informational videos that feature scenarios relevant to diverse communities. These videos could illustrate common situations beneficiaries might encounter, such as navigating prescription drug benefits, and offer guidance in several languages, including sign language. Incorporating visual aids and culturally resonant storytelling can significantly enhance comprehension and engagement, making complex information more accessible and relatable. This approach not only ensures consistency in the information conveyed across different languages and cultures but also directly addresses the diverse informational needs of all beneficiary groups, thereby enhancing understanding and accessibility.

Additionally, ensuring that documents are accessible to those with disabilities involves more than compliance with technical standards; it requires a holistic approach to accessibility that considers the varied ways beneficiaries interact with written materials, including the provision of documents in Braille, large print, audio formats, and ensuring compatibility with screen readers and other accessibility tools. It is equally crucial to guide the consumer through the nuances of this new policy. This includes reiterating what Part D entails and briefly explaining Medicare prescription coverage in its entirety. While it may seem redundant, this step is vital to clarifying any confusion for the general impacted Medicare consumer, ensuring that everyone fully understands the scope and benefits of the policy changes, thereby fostering a more inclusive and informed beneficiary community.

The NHC highlights the critical need for these materials to not only be available in various languages and accessible formats but also to be disseminated through channels that reach beneficiaries where they are. This encompasses a broad spectrum of distribution methods including online platforms, physical mailings, community centers, and health care facilities, to ensure the widest possible reach. To further enhance clarity and safeguard against potential fraud, each model document associated with the MPPP should contain a clear, upfront explanation of its purpose to help beneficiaries understand the required actions. This clarity is crucial to helping beneficiaries navigate their choices effectively. Furthermore, it is essential to incorporate detailed examples within these materials, illustrating what new coverage will entail. This should include samples of the types of bills beneficiaries might receive, clear descriptions of legitimate notices from the Federal government regarding outstanding coverage payments, and the various mediums through which these communications may occur—be it mail, electronically, or by phone. Providing such specific examples serves a dual purpose: it aids beneficiaries in recognizing official correspondence and understanding their billing statements, and it acts as a preventative measure against fraud by informing beneficiaries of the legitimate formats of communication, thereby making it harder for fraudulent entities to exploit any loopholes. By taking these steps, CMS can significantly improve beneficiaries' ability to effectively manage their health care options, while also protecting them from potential scams.

Continuous Improvement

Meeting the evolving needs of beneficiaries requires continuous improvement, a process that extends beyond the launch of the MPPP. To this end, the NHC highlights the crucial role of feedback and engagement from all stakeholders in the Medicare ecosystem — beneficiaries, health care providers, Part D sponsors, and patient organizations — in shaping a program that is truly responsive and beneficial. In light of this, the NHC recommends the establishment of a structured, iterative feedback loop that allows CMS to gather insights, suggestions, and concerns from stakeholders on a regular basis. This process should be transparent and accessible, encouraging open dialogue and the sharing of experiences with the MPPP. Such a feedback mechanism will enable CMS to identify areas of success as well as opportunities for improvement, ensuring that the program remains aligned with its goal of reducing the financial burden of prescription medications for Medicare beneficiaries.

Moreover, the NHC suggests the incorporation of these mechanisms in a manner that allows for the rapid implementation of changes to the MPPP based on stakeholder feedback. This could include regular updates to the model documents, adjustments to program policies, and enhancements to educational and outreach materials. By adopting an agile approach to program management, CMS can ensure that the MPPP remains a dynamic and effective tool in supporting the health and well-being of Medicare beneficiaries.

Additionally, the NHC sees significant value in conducting periodic reviews of the MPPP's impact, utilizing both quantitative data and qualitative feedback to assess the program's effectiveness in meeting its objectives. These reviews should examine not only the administrative and operational aspects of the program but also its effect on beneficiaries' access to necessary medications and their overall satisfaction with the

program. Insights gained from these reviews can inform targeted improvements, ensuring that the MPPP continues to serve as a vital resource for those it aims to help.

Enhancing Procedural Clarity for Beneficiaries

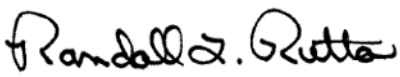
In addition to these improvements, a specific area that requires immediate attention is the process concerning the rights of beneficiaries to be reinstated after termination from the MPPP due to non-payment. Currently, the "Part D Sponsor Notice for Failure to Make Payments" lacks explicit instructions or clarity on how beneficiaries can re-enroll in the MPPP once they have settled their overdue payments. This oversight can lead to unnecessary exclusion from the program, impacting beneficiaries' access to necessary medications. To rectify this, the NHC strongly recommends the inclusion of a new section in the model documents that details the reinstatement process. This section should provide clear, step-by-step guidance on how beneficiaries can regain their enrollment status after fulfilling their payment obligations, thereby ensuring they understand that re-enrollment is possible and the steps they need to initiate it. By making this process transparent and straightforward, CMS can better support beneficiaries in maintaining continuous access to essential care.

Furthermore, to prevent any confusion regarding annual enrollment requirements, we propose the introduction of a 'Year End' notice to be issued to all MPPP participants. This notice should serve to remind beneficiaries that their enrollment in the MPPP does not automatically continue into the next year and that they must re-enroll annually. Additionally, this notice could provide useful information on how to 'close out' their payments for the current year's program, further assisting beneficiaries in managing their health care finances effectively and ensuring clarity about the continuity of their benefits. This proactive communication is crucial for aiding beneficiaries in understanding the annual nature of the program and facilitating a smooth transition into the subsequent year.

Conclusion

The NHC appreciates the opportunity to provide comments to CMS in response to its ICR on MPPP Model Documents. We look forward to continued collaboration with CMS to ensure the successful implementation and ongoing improvement of the MPPP. Please do not hesitate to contact Eric Gascho, Senior Vice President of Policy and Government Affairs, if you or your staff would like to discuss these comments in greater detail. He is reachable via e-mail at egascho@nhcouncil.org.

Sincerely,



Randall L. Rutta
Chief Executive Officer

April 29, 2024

Dr. Meena Seshamani
Director, Center for Medicare
Deputy Administrator, Centers for Medicare & Medicaid Services
7500 Security Boulevard
Baltimore, MD 21244

Dear Dr. Seshamani,

Our organizations, The Alliance for Aging Research (AAR) and the Patient Access Network Foundation (PAN Foundation), appreciate the ongoing opportunity to work with the Centers for Medicare & Medicaid Services (CMS) on implementing critical elements of the Medicare Prescription Payment Plan (M3P). We thank CMS for the opportunity to comment on both the Part I and Part II guidance for M3P and similarly appreciate being able to provide feedback on the model forms and education materials provided by CMS through the Information Collection Request (ICR) related to M3P implementation. Our comments to the documents included in the ICR are attached as Appendix A and briefly summarized below.

About AAR

The Alliance for Aging Research is the leading nonprofit organization dedicated to changing the narrative to achieve healthy aging and equitable access to care. The Alliance strives for a culture that embraces healthy aging as a greater good and values science and investments to advance dignity, independence, and equity.

For more than 35 years, the Alliance has guided efforts to substantially increase funding and focus for aging at the National Institutes of Health and Food and Drug Administration; built influential coalitions to guide groundbreaking regulatory improvements for age-related diseases; and created award-winning, high-impact educational materials to improve the health and well-being of older adults and their family caregivers.

About PAN Foundation

The Patient Access Network Foundation is a national patient advocacy organization and charitable foundation that for two decades, has been dedicated to helping underinsured people living with life-threatening, chronic, and rare diseases get the medications and treatments they need by assisting with their out-of-pocket costs. Additionally, through our national and grassroots efforts, we advocate for improved affordability and access to care. Since 2004, we have provided more than 1.1 million underinsured individuals with $4 billion in financial assistance.

Comments to Model Forms and Education Materials

As previously noted, we have included as Appendix A redlined versions of the forms to help CMS visualize the changes we would like to see before the forms are finalized. Overall, we urge CMS to incorporate language that reflects the following:

- Reiterating in each form the specifics of the M3P program, including:
    - stating it is a government program,
    - stating individuals will never pay more than $2,000 out-of-pocket in 2025,
    - explaining the grace period, and
    - explaining the grievance process.
- Defining comprehensively and consistently the "other programs" to lower costs and information on how to learn more about these alternatives.
- Clarifying that the M3P program is not being sold to beneficiaries; this is a new benefit akin to other benefits in the Medicare program.
- Clarifying that M3P does not replace a prescription drug plan or a Medicare Advantage prescription drug plan, as the nomenclature "Medicare Prescription Payment Plan" may confuse beneficiaries because of the word "plan."
- Incorporating thematic elements of how smoothing works, specifically explaining how the new cap limiting annual costs helps beneficiaries to better manage and pay for costs before they reach the cap.

We also encourage CMS to develop a standardized form for plans to send to beneficiaries enrolled in the M3P at the end of the calendar year. This form should include:

- Notice that the beneficiary will need to re-enroll in the M3P with their selected plan for the following year – even if they are remaining with the same plan – in order to continue to use the program.
- Information about how to make their final payment for the M3P for the current year, including information about the grace period and grievance process.

Lastly, CMS should ensure that plans are able to walk beneficiaries through specifics of the M3P program either by phone or through the plan's website. Specific to the website, we recommend inclusion of 1) a payment calculator and 2) an easy-to-understand infographic of how enrollment in the M3P program will benefit the beneficiary as well as a flow chart of the mechanics of the benefit.

Next Steps and Conclusion

Thank you again for the opportunity to comment on these model forms and education materials. We look forward to continuing our partnership with CMS to ensure that beneficiaries can easily access and benefit from these essential policy reforms. If you have questions about these recommendations or would like to discuss further, please contact us at mward@agingresearch.org or aniles@panfoundation.org.

Sincerely,

Michael Ward
VP of Public Policy and Government Relations
Alliance for Aging Research

Amy Niles
Chief Mission Officer
Patient Access Network Foundation

Attachment

Medicare Allows Participants to Manage Monthly Drug Costs Through Interest-Free Payment Installments~~Consider Managing Your Monthly Drug Costs with the Medicare Prescription Payment Plan~~

You are receiving this notice because you have been prescribed, or have previously taken, a ~~prescription~~medication ~~expected to~~ that will cost you $600 or more each time you fill the prescription. Though there is now a $2,000 annual limit on your out-of-pocket costs for medications in Medicare, ~~exceed $600 in out-of-pocket costs and~~ ~~You might~~ you may benefit from participating in the Medicare Prescription Payment Plan, ~~because you have high drug costs~~. This new ~~government~~ payment option works with your current drug coverage, and it can help you manage your drug costs by spreading them across ~~monthly payments that vary throughout~~ **the remainder of the year** (January – December).

What's the Medicare Prescription Payment Plan?

The Medicare Prescription Payment Plan is a new ~~government~~ payment option ~~established~~created by Congress to help you manage your out-of-pocket drug costs, starting ~~in~~ January 1, 2025. All Medicare drug plans and Medicare health plans with drug coverage (like a Medicare Advantage Plan) must offer this payment option, and all plans use the same formula to calculate your monthly payments. If you choose to participate in the Medicare Prescription Payment Plan, each month you'll pay your plan premium (if you have one) and you ~~will~~ receive a separate (?) bill from your health or drug plan for the out-of-pocket costs you owe for your prescription drugs. ~~It is important to note that if~~If you are enrolled in the Medicare Prescription Payment Plan, you ~~will~~won't ~~not be~~ pay~~ing~~ for your prescription drugs at the pharmacy counter. Instead, you will pay the amount you owe in monthly installments over the remainder of the current year.~~If you select this payment option, each month you'll pay your plan premium (if you have one) and you'll get a bill from your health or drug plan for your prescription drugs (instead of paying the pharmacy).~~

Participating in this payment option is voluntary. Anyone with a Medicare drug plan or a Medicare health plan with drug coverage can use this payment option, which applies to all prescription drugs covered by Part D. It doesn't cost anything to participate in the Medicare Prescription Payment Plan, and you won't pay any interest or fees on the amount you owe, even if your payment is late. ~~If you don't participate in the Medicare Prescription Payment Plan, you will continue to pay for your prescription drugs at the pharmacy counter, and you will not have the benefit of spreading these costs throughout the year.~~

How will my costs work with this payment option?

The new prescription drug law ~~aps~~limits your out-of-pocket costs ~~at~~to $2,000 in 2025 and eliminates the coverage gap (known as the "donut hole"). This means you will not~~'ll never~~ pay more than $2,000 in out-of- pocket drug costs in 2025. **This is true for everyone with Medicare drug coverage, even if you don't join the Medicare Prescription Payment Plan.**

If you enroll in the~~a~~ Medicare Prescription Payment Plan, ~~W~~when you fill a prescription for a drug covered by Part D, you won't pay your pharmacy (including mail- order and specialty pharmacies). Instead, you'll get a bill each month from your plan. Your monthly bill is based on what you owe for any prescriptions you get filled, plus your previous month's balance, divided by the number of months left in the year.

Note: Your payments might change every month, so you might not know what your exact bill will be ahead of time. Future payments amounts ~~might~~will increase if you fill a new prescription or refill an existing prescription. Also, note that if you add a new prescription later in the year there will be fewer months remaining in the year to spread out the payment, so your monthly payment will be larger.~~Future payments might increase when you fill a new prescription or refill an existing prescription because as new out-of-pocket drug costs are added into your monthly payment, there are fewer months left in the year to spread out your payments.~~

Will this payment option help me?

It depends on your situation. If you have high out-of-pocket drug costs, this payment option spreads out what you'll pay each month across the year (January – December), so you don't have to pay out-of-pocket costs to the pharmacy. **This payment option might help you manage and budget for your expenses, but it doesn't save you money or lower your drug costs.** Visit Medicare.gov/basics/costs/help/drug-costs to learn about programs that can help lower your drug costs.

~~How will my costs work with this payment option?~~

~~The new prescription drug law caps your out-of-pocket costs at $2,000 in 2025 and eliminates the coverage gap (known as the "donut hole"). This means you'll never pay more than $2,000 in out-of-pocket drug costs in 2025. **This is true for everyone with Medicare drug coverage, even if you don't join the Medicare Prescription Payment Plan.**~~

~~When you fill a prescription for a drug covered by Part D, you won't pay your pharmacy (including mail-order and specialty pharmacies). Instead, you'll get a bill each month from your plan. Your monthly bill is based on what you owe for any prescriptions you get, plus your previous month's balance, divided by the number of months left in the year.~~

~~**Note: Your payments might change every month, so you might not know what your exact bill will be ahead of time.** Future payments might increase when you fill a new prescription or refill an existing prescription because as new out-of-pocket drug costs are added into your monthly payment, there are fewer months left in the year to spread out your payments.~~

How do I know if this payment option might not be right for me?

This payment option might not be helpful for you if:

- You get assistance through the Medicare Extra Help (also known as the Low-Income Subsidy Program)~~from Medicare~~.
- You qualify for a Medicare Savings Program.
- You get help paying for your drugs from other organizations, like a State Pharmaceutical Assistance Program (SPAP), a state AIDS Drug Assistance Program or other health coverage.
- You qualify for Manufacturer's Pharmaceutical Assistance Programs (sometimes called Patient Assistance Programs (PAPs)): A program from drug manufacturers to help lower drugs costs for people with Medicare. Visit go.medicare.gov/pap to learn more.
- You are receiving financial assistance from a charitable foundation.
- Your yearly drug costs are low, and relatively the same from one month to the next~~. Your drug costs are the same each month.~~
- You're considering signing up for the payment option late in the calendar year (after September).
- You don't want to change how you pay for your drugs.

Who can help me decide if I should sign up for this payment option?

- **Your plan:** Visit your plan's website, or call your plan to get more information. Your plan's phone number is on the back of your membership card.
- **Medicare:** Visit Medicare.gov/tbd, or call 1-800-MEDICARE (1-800- 633-4227), 24 hours a day, 7 days a week. TTY users can call 1-877-486-2048.
- **State Health Insurance Program (SHIP):** Visit shiphelp.org to get the phone number for your local SHIP and get free, personalized health insurance counseling.

How do I sign up for this payment option?

To sign up for this payment option, visit your plan's website or call your plan. You can find your plan's phone number on the back of your membership card. If you need to pick up a prescription urgently, the fastest way to use this payment option is to call your plan.

Need this information in another format or language?
To get this material in other formats like large print, braille, or another language, contact your Medicare drug plan. If you need help contacting your plan, call: 1-800-MEDICARE (1-800-633-4227).

Medicare Prescription Payment Plan participation request form

FIRST name:	LAST name:	MIDDLE initial (optional):

Medicare Number: _ _ _ _ - _ _ _ - _ _ _ _

Birth date: (MM/DD/YYYY) (/ /)	Phone number: ( )

Permanent residence street address (don't enter a P.O. Box unless you're experiencing homelessness):

City:	County (optional):	State:	ZIP code:

Mailing address, if different from your permanent address (P.O. Box allowed):
Address: City: State: ZIP code:

Do you currently get help paying your prescription drug costs from a program like Medicare's Extra Help, a State Pharmaceutical Assistance Program (SPAP), Indian Health Services, or other health insurance?
☐ Yes ☐ No ☐ Not sure

- I understand this form is a request to participate in the Medicare Prescription Payment Plan. <Plan Name> will contact me if they need more information.
- I understand that signing this form means that I've read and understand the form <and the attached terms and conditions (if included)>.
- **<Plan Name> will send me a notice to let me know when my participation in the Medicare Prescription Payment Plan is active.** Until then, I understand that I'm not a participant in the Medicare Prescription Payment Plan.

Signature:	**Date:**

Name:	Address (Street, City, State, ZIP code):
Phone number: ( )	Relationship to participant (if signing on behalf of the beneficiary):

How to submit this form

Submit your completed form to:
<Plan Name>
<Plan address>
<Plan address>
<Plan address>
<Plan fax number if applicable>
<Plan email if plan chooses to accept forms via email>

Commented [A1]: Comment to CMS: Please clarify why there is a need to check whether someone gets assistance from another program such as Extra Help. What will the plan do with this information?

Commented [A2]: Comment to CMS: Please clarify that the form can be submitted electronically and not just as a PDF.

Commented [A3R2]: Comment to CMS: When submitted electronically, plans should send an auto response acknowledging submission of the form and that those opting in should hear back from their plan regarding their M3P status in 24 hours and if not to call the plan's 1-800 number.

<Plans can insert their Medicare Prescription Payment Plans terms and conditions on the back of this form or attach them separately>

Exhibit 1 – Part D Sponsor Notice to Acknowledge Acceptance of Election in the Medicare Prescription Payment Plan

Referenced in [insert draft part 2 guidance section]

<Part D sponsors may insert a title for the notice, such as "You're now participating in the Medicare Prescription Payment Plan">

<Member #>

<RxID>

<RxGroup>

<RxBin>

<RxPCN>

<Date>

Dear <Name of Member>,

Welcome to the Medicare Prescription Payment Plan, a payment option that works with your <plan name>. Your participation starts on <insert date>.

What happens now?

1. We'll let your pharmacy (including mail-order and specialty pharmacies) know that you're using this payment option.
2. When you ~~fill~~ pick up a prescription for ~~any~~ drugs covered by Part D through the end of the current year, you won't pay your pharmacy for the prescription. Instead, ~~but~~ your out-of-pocket responsibility will be added to your Medicare Prescription Payment Plan's outstanding balance.
3. Each month <plan name> will send you a bill with the amount you owe, when it's due, and information on how to make a payment. You'll get a separate bill for your monthly plan premium (if you have one).

How is my monthly bill calculated?

Your monthly bill is based on what you owe for any prescriptions you ~~get~~ fill after opting into the payment plan for the remainder of the calendar year, plus your previous month's balance, divided by the number of months left in the year. This calculation allows you to spread your costs over ~~the course of the year~~zero-interest payment installments, instead of paying it all at once.

Your payments might change every month, so you might not know what your exact bill will be ahead of time. Future payments ~~might~~will increase if you fill a new prescription or refill an existing prescription. Also, note that if you add a new prescription later in the year there will be fewer months remaining in the year to spread out the payment, so your monthly payment will be larger. Note that you'll never pay any interest or fees on what you owe, even if your payment is late.

~~You will be billed separately for your out-of-pocket prescription drug costs from your monthly premium. Paying plan premiums isare the highest priority to maintain enrollment in Part D. However, yYou may be removed from the program if you inadvertently apply a payment to your premium.Future payments might increase when you fill a new prescription or refill an existing prescription because as new out-of-pocket costs are added into your monthly payment, there are fewer months left in the year to spread out~~

~~your payments. You'll never pay any interest or fees on the amount you owe, even if your payment is late.~~

Remember, in a single calendar year (Jan – Dec), you'll never pay more than:

- The total amount you would have paid out of pocket to the pharmacy.
- The Medicare drug coverage annual out-of-pocket maximum (which is $2,000 in 2025).

What happens if I don't pay my bill?

We'll send you a reminder if you miss a payment. ~~and payment is not received by?.~~ ~~I~~if you don't pay your bill by the date listed and your payment has not been received by X/XX/XXXX *(whatever day is 2 months after the start of the grace period)*. ~~you'll be removed from the MPPP."~~ ~~If you don't pay your bill by the date listed in that reminder,~~ you'll be removed from the Medicare Prescription Payment Plan. ~~Like any other debt, y~~

~~Y~~~~ou're required to pay the amount you owe~~You will be billed the amount you owe. However, ~~A~~always pay your <plan name> premium first (if you have one), so you don't lose your drug coverage. Paying plan premiums is the highest priority to maintain enrollment in Part D.

If you think that we've made a mistake with the amount you owe, call us at <phone number>. You also have the right to follow the grievance process found in your <insert "Member Handbook" or "Evidence of Coverage," as appropriate>.

Commented [A1]: Comment to CMS: The sentence at the end of this section would benefit from some language around when beneficiaries can be reinstated for good cause and what that process is, especially if it is different than the appeals/grievance system. Section 80.2.2 of the Part I guidance talks about this but does not define what "good cause" is, but says there must be a" credible statement" that they couldn't pay due to given circumstances.

~~Can I leave the Medicare Prescription Payment Plan~~What if I no longer want to ~~stay~~use ~~in~~ the Medicare Prescription Payment Plan?

You can leave ~~(disenroll?)~~ the Medicare Prescription Payment Plan at any time by calling us at <phone number>. If you still owe a balance, you're required to pay the amount you owe, even though you're no longer participating in the program. You can choose to pay the remaining amount all at once or be billed monthly. If you leave ~~(disenroll?)~~, your Medicare drug coverage and other Medicare benefits won't be affected, and you'll go back to paying the pharmacy directly for all your out-of-pocket drug costs.

If you leave <current plan name> or change to a new Medicare drug plan or Medicare health plan with drug coverage (like a Medicare Advantage Plan) your participation in the Medicare Prescription Payment Plan will end. If you change plans, and you'd like to join the Medicare Prescription Payment Plan offered through your new plan, contact your new plan.

Enrollment in the Medicare Prescription Payment Plan **lasts through the end of the current calendar year**. If you wish to re-enroll in the Medicare Prescription Payment Plan for next year, you will need to visit your plan's website or call after you've selected your plan for <future plan year, i.e., 2026>.

Are there programs that can help lower my costs?

Commented [A2]: Comment to CMS: Programs listed to lower costs should be consistent across all documents.

While the Medicare Prescription Payment Plan spreads out your costs, it doesn't lower them. However, you may be eligible for programs that can help lower your costs, like:

- **Extra Help:** A Medicare program that helps pay your Medicare drug costs if you have limited income and resources. Visit secure.ssa.gov/i1020/start to find out if you qualify and apply. You can also apply with your state's Medicaid office. Visit Medicare.gov/basics/costs/help/drug-costs to learn more.
- **Medicare Savings Program**: A state-run program that helps people with limited income and resources pay some or all of their Medicare premiums, deductibles, and coinsurance. Visit Medicare.gov/medicare-savings-programs to learn more.

- **State Pharmaceutical Assistance Program (SPAP):** A program that may include coverage for your Medicare drug plan premiums and/or cost sharing. SPAP contributions may count toward your Medicare drug coverage out-of-pocket limit. Visit go.medicare.gov/spap to learn more.
- **Manufacturer's Pharmaceutical Assistance Programs** (sometimes called Patient Assistance Programs (PAPs)): A program from drug manufacturers to help lower drugs costs for people with Medicare. Visit go.medicare.gov/pap to learn more.
- **Charitable Patient Assistance Programs:** A program from a charitable foundation that provides financial assistance for people, including Medicare beneficiaries to help them ~~with Medicare to~~ afford their medications. Visit: https://www.panfoundation.org/fundfinder/ to learn more.
- **AIDS Drug Assistance Programs:** If you are living with HIV, you may be eligible for your state's AIDS Drug Assistance Program (ADAP) administered by your state health department. Visit https://adap.directory/ to learn more.

Commented [A3]: Comment to CMS: The Medicare website does not include a link to FundFinder that allows those in need of help with their medication costs to track more than 200 patient assistance funds from nine charitable organizations. We recommend that CMS include a link on their website to this resource.

Many people qualify for savings and don't realize it. Visit Medicare.gov/basics/costs/help, or contact your local Social Security office to learn more. Find your local Social Security office at secure.ssa.gov/ICON/main.jsp or call 1-800-772-1213. TTY users can call 1-800-325-0778.

Exhibit 2 – Part D Sponsor Initial Notice for Failure to Make Payments under the Medicare Prescription Payment Plan

Referenced in [insert draft part 2 guidance section]

<Part D sponsors may insert a title for the notice, such as "Urgent: Pay your Medicare Prescription Payment Plan bill">

<Member #>

<RxID>

<RxGroup>

<RxBin>

<RxPCN>

Dear < Member>:

~~We didn't get your monthly payment for the Medicare Prescription Payment Plan that was due~~ We have not received your monthly payment for the Medicare Prescription Payment Plan that was~~ere~~ due.<insert payment due date>. To continue to stay in and benefit from the Medicare Prescription Payment Plan, you must pay <insert the full amount or a partial amount(s) should the plan choose to allow enrollees to pay the balance over separate payments> by <insert date for the end of the grace period (i.e., the date that is two calendar months from the first day of the month for which the balance is unpaid or the first day of the month following the date on which the payment is requested, whichever is later)>.

This letter only applies to your participation in the Medicare Prescription Payment Plan. Your Medicare drug coverage and other Medicare benefits won't be affected, and you'll continue to be enrolled in <plan name> for your drug coverage.

How do I pay my bill?

You can choose to pay the amount you owe all at once or be billed monthly. You'll never pay any interest or fees on the amount you owe.

Commented [A1]: Comment to CMS: Can an overdue amount be paid monthly? Or does that balance need to be paid by the date listed? If the latter, then the language on how to pay a bill is confusing and should be clarified.

You owe <insert unpaid>. You can pay:

- Online at <plan's website>, by credit/debit card.
- Through the mail, by check.
- <insert other payment methods offered by the plan like electronic funds transfer (including automatic charges of an account at a financial institution or credit or debit card account)>.

If you have questions about your payment, call us at <phone number>, <days and hours of operation>. TTY users can call < TTY number>.

What happens if I don't pay my bill?

You will be billed the amount you owe. If you don't pay your bill by <insert effective date>, you'll no longer be enrolled in the Medicare Prescription Payment Plan through <plan sponsor>. As of <effective date>, you'll pay the pharmacy directly for your out-of-pocket drug costs.

~~Like any other debt, y~~You're ~~required to pay the amount you owe.~~ As long as you continue to pay your plan premium (if you have one), you'll still have drug coverage through <plan name>.

What if I think there's been a mistake?

If you think that we've made a mistake, call us at <phone number>. You also have the right to ask us to reconsider our decision through a grievance process. Check your <insert "Member Handbook" or "Evidence of Coverage," as appropriate>.

What if I can't afford to pay both my plan premium and my Medicare Prescription Payment Plan payment?

Always pay your <plan name> premium first (if you have one). If needed, we can apply a payment you've made toward your **Medicare Prescription Payment Plan** balance to your plan premium instead. Call us at <phone number> to discuss this option.

Are there programs that can help lower my costs?

While the Medicare Prescription Payment Plan spreads out your costs, it doesn't lower them. However, you may be eligible for programs that can help lower your costs, like:

- **Extra Help:** A Medicare program that helps pay your Medicare drug costs if you have limited income and resources. Visit secure.ssa.gov/i1020/start to find out if you qualify and apply. You can also apply with your state's Medicaid office. Visit Medicare.gov/basics/costs/help/drug-costs to learn more.
- **Medicare Savings Program**: A state-run program that helps people with limited income and resources pay some or all of their Medicare premiums, deductibles, and coinsurance. Visit Medicare.gov/medicare-savings-programs to learn more.
- **State Pharmaceutical Assistance Program (SPAP):** A program that may include coverage for your Medicare drug plan premiums and/or cost sharing. SPAP contributions may count toward your Medicare drug coverage out-of-pocket limit. Visit go.medicare.gov/spap to learn more.
- **Manufacturer's Pharmaceutical Assistance Programs** (sometimes called Patient Assistance Programs (PAPs)): A program from drug manufacturers to help lower drugs costs for people with Medicare. Visit go.medicare.gov/pap to learn more.
- **Charitable Patient Assistance Programs:** A program from a charitable foundation that provides financial assistance for people, including Medicare beneficiaries to help them ~~with Medicare to~~ afford their medications. Visit: https://www.panfoundation.org/fundfinder/ to learn more.
- **AIDS Drug Assistance Programs:** If you are living with HIV, you may be eligible for your state's AIDS Drug Assistance Program (ADAP) administered by your state health department. Visit https://adap.directory/ to learn more.

Many people qualify for savings and don't realize it. Visit Medicare.gov/basics/costs/help, or contact your local Social Security office to learn more. Find your local Social Security office at secure.ssa.gov/ICON/main.jsp or call 1-800-772-1213. TTY users can call 1-800-325-0778.

Note: The programs listed above can help lower your costs, but they can't help you pay off your Medicare Prescription Payment Plan balance.

Commented [A2]: Comment to CMS: The Medicare website does not include a link to FundFinder that allows those in need of help with their medication costs to track more than 200 patient assistance funds from nine charitable organizations. We recommend that CMS include a link on their website to this resource.

Exhibit 3 - Part D Sponsor Notice for Failure to Make Payments under Medicare Prescription Payment Plan - Notification of Termination of Participation in the Medicare Prescription Payment Plan

Referenced in [insert draft part 2 guidance section]

<Part D sponsors may insert a title for the notice, such as "Important: Your participation in the Medicare Prescription Payment Plan has ended">

<Member #>

<RxID>

<RxGroup>

<RxBin>

<RxPCN>

<Date>

Dear < Member>,

On <date of initial notification of failure to pay>, we sent you a letter letting you know your monthly payment for the Medicare Prescription Payment Plan was overdue. The letter explained that if you didn't make your payment by <insert time frame>, ~~we'd end~~ your participation in the Medicare Prescription Payment Plan would end.

Starting <insert effective date, which should be the same date as this letter>, you're no longer participating in the Medicare Prescription Payment Plan through <plan sponsor> because we didn't ~~get~~ receive your monthly payment. Like any other debt, you're still required to pay the amount you owe, $<amount owed>.

As of <effective date>, you'll pay the pharmacy directly for all your out-of-pocket drug costs.

Commented [A1]: Comment to CMS: Clarify that this is for future out-of-pocket drug costs to distinguish from balance owed.

This letter only applies to your participation in the Medicare Prescription Payment Plan. Your Medicare drug coverage and other Medicare benefits won't be affected, and you'll continue to be enrolled in <plan name> for your drug coverage.

How do I pay my balance?

You can choose to pay the amount you owe all at once or be billed monthly. You'll never pay any interest or fees on the amount you owe.

You owe <insert unpaid>. You can pay:

- Online at <plan's website>, by credit or debit card.
- Through the mail, by check.
- <insert other payment methods offered by the plan sponsor like electronic funds transfer (including automatic charges of an account at a financial institution or credit or debit card account)>.

If you have questions about your payment, call us at <phone number>, <days and hours of operation>. TTY users can call <TTY number>.

What if I think there's been a mistake?

If you think that we've made a mistake, or there is an unforeseen emergency that impacted your ability to submit your payment on time (such as an inpatient hospitalization), call us at <phone number>. You also have the right to ask us to reconsider our decision through the grievance process in your <insert "Member Handbook" or "Evidence of Coverage," as appropriate>.

Can I use this payment option in the future?

Yes, once you pay the total amount you owe.

Are there programs that can help lower my costs?

You may be eligible for programs that can help lower your costs, like:

- **Extra Help:** A Medicare program that helps pay your Medicare drug costs if you have limited income and resources. Visit secure.ssa.gov/i1020/start to find out if you qualify and apply. You can also apply with your state's Medicaid office. Visit Medicare.gov/basics/costs/help/drug-costs to learn more.
- **Medicare Savings Program**: A state-run program that helps people with limited income and resources pay some or all of their Medicare premiums, deductibles, and coinsurance. Visit Medicare.gov/medicare-savings-programs to learn more.
- **State Pharmaceutical Assistance Program (SPAP):** A program that may include coverage for your Medicare drug plan premiums and/or cost sharing. SPAP contributions may count toward your Medicare drug coverage out-of-pocket limit. Visit go.medicare.gov/spap to learn more.
- **Manufacturer's Pharmaceutical Assistance Programs** (sometimes called Patient Assistance Programs (PAPs)): A program from drug manufacturers to help lower drugs costs for people with Medicare. Visit go.medicare.gov/pap to learn more.
- **Charitable Patient Assistance Programs:** A program from a charitable foundation that provides financial assistance for people, including Medicare beneficiaries to help them ~~with Medicare to~~ afford their medications. Visit: https://www.panfoundation.org/fundfinder/ to learn more.
- **AIDS Drug Assistance Programs:** If you are living with HIV, you may be eligible for your state's AIDS Drug Assistance Program (ADAP) administered by your state health department. Visit https://adap.directory/ to learn more.

Many people qualify for savings and don't realize it. Visit Medicare.gov/basics/costs/help, or contact your local Social Security office to learn more. Find your local Social Security office at secure.ssa.gov/ICON/main.jsp or call 1-800-772-1213. TTY users can call 1-800-325-0778.

Note: The programs listed above can help lower your costs, but they can't help you pay off your Medicare Prescription Payment Plan balance.

Commented [A2]: Comment to CMS: The Medicare website does not include a link to FundFinder that allows those in need of help with their medication costs to track more than 200 patient assistance funds from nine charitable organizations. We recommend that CMS include a link on their website to this resource.

Exhibit 4 - Part D Sponsor Notification of Voluntary Removal from the Medicare Prescription Payment Plan

Referenced in [insert draft part 2 guidance section]

<Part D sponsors may insert a title for the notice, such as "You're no longer participating in the Medicare Prescription Payment Plan through <plan sponsor>">

<Member #>

<RxID>

<RxGroup>

<RxBin>

<RxPCN>

Dear <Member>,

~~You're gettingYou are receiving this letter because~~

- ~~you either asked to stop participating in the Medicare Prescription Payment Plan, this payment option, or you changed your Medicare drug plan or Medicare health plan with drug coverage (like a Medicare Advantage Plan), or it is the end of the current plan year. If you changed plans, and you'd like to join the Medicare Prescription Payment Plan offered through your new plan, contact your new plan.~~

Starting <insert effective date>, you're no longer participating in the Medicare Prescription Payment Plan through <plan sponsor>. As of <effective date>, you'll pay the pharmacy directly for your out-of-pocket drug costs.

You are receiving this letter because you:

1) Asked to stop participating in the Medicare Prescription Payment Plan,

2) Changed your Medicare drug plan or Medicare health plan with drug coverage (such as a Medicare Advantage Plan), **or**

3) It is the end of the current plan year.

If you would like to re-enroll in the Medicare Prescription Payment Plan, please re-enroll by visiting your plan's website or by calling your plan. If you changed plans, contact your new plan.

~~You're getting this letter because you either asked to stop participating in this payment option, or you changed your Medicare drug plan or Medicare health plan with drug coverage (like a Medicare Advantage Plan). If you changed plans, and you'd like to join the Medicare Prescription Payment Plan offered through your new plan, contact your new plan.~~

This letter only applies to your participation in the Medicare Prescription Payment Plan. Your Medicare drug coverage and other Medicare benefits won't be affected.~~, and you'll continue to be enrolled in <plan name> for your drug coverage.~~

How do I pay my balance?

You can choose to pay the amount you owe all at once or be billed monthly. You'll never pay any interest or fees on the amount you owe, even if your payment is late.

You owe <insert unpaid>. You can pay:

- Online at <plan's website>, by credit or debit card.
- Through the mail, by check.
- <insert other payment methods offered by the plan sponsor like electronic funds transfer (including automatic charges of an account at a financial institution or credit or debit card account)>.

If you have questions about your payment, call us at <phone number>, <days and hours of operation>. TTY users can call <TTY number>.

What happens if I don't pay my balance?

~~Like any other debt,~~ You are required to ~~you're required to~~ pay the amount you owe on the Medicare Prescription Payment Plan. As long as you continue to pay your plan premium (if you have one), you'll still have drug coverage.

Can I use this payment option in the future?

- **If you're still in <plan name>:** Yes. Visit <insert PDP webpage where the application is>, or call us at <phone number> <days and hours of operation>. TTY users can call <TTY number>.
- **If you're joining a new plan:** Yes. All Medicare drug plans and Medicare health plans with drug coverage must offer this payment option. No matter what Medicare drug plan you're in, you can choose to rejoin the Medicare Prescription Payment Plan at any time.

Are there programs that can help lower my costs?

You may be eligible for programs that can help lower your costs, like:

- **Extra Help:** A Medicare program that helps pay your Medicare drug costs if you have limited income and resources. Visit secure.ssa.gov/i1020/start to find out if you qualify and apply. You can also apply with your state's Medicaid office. Visit Medicare.gov/basics/costs/help/drug-costs to learn more.
- **Medicare Savings Program**: A state-run program that helps people with limited income and resources pay some or all of their Medicare premiums, deductibles, and coinsurance. Visit Medicare.gov/medicare-savings-programs to learn more.
- **State Pharmaceutical Assistance Program (SPAP):** A program that may include coverage for your Medicare drug plan premiums and/or cost sharing. SPAP contributions may count toward your Medicare drug coverage out-of-pocket limit. Visit go.medicare.gov/spap to learn more.
- **Manufacturer's Pharmaceutical Assistance Programs** (sometimes called Patient Assistance Programs (PAPs)): A program from drug manufacturers to help lower drugs costs for people with Medicare. Visit go.medicare.gov/pap to learn more.
- **Charitable Patient Assistance Programs:** A program from a charitable foundation that provides financial assistance for people, including Medicare beneficiaries to help them afford ~~with Medicare to afford~~ their medications. Visit: https://www.panfoundation.org/fundfinder/ to learn more.
- **AIDS Drug Assistance Programs:** If you are living with HIV, you may be eligible for your state's AIDS Drug Assistance Program (ADAP) administered by your state health department. Visit https://adap.directory/ to learn more.

Commented [A1]: Comment to CMS: Can an overdue amount be paid monthly? Or does that balance need to be paid by the date listed? If the latter, then the language on how to pay a bill is confusing and should be clarified.

Commented [A2]: Comment to CMS: The Medicare website does not include a link to FundFinder that allows those in need of help with their medication costs to track more than 200 patient assistance funds from nine charitable organizations. We recommend that CMS include a link on their website to this resource.

Many people qualify for savings and don't realize it. Visit Medicare.gov/basics/costs/help, or contact your local Social Security office to learn more. Find your local Social Security office at secure.ssa.gov/ICON/main.jsp or call 1-800-772-1213. TTY users can call 1-800-325-0778.

Note: The programs listed above can help lower your costs, but they can't help you pay off your Medicare Prescription Payment Plan balance.

April 29, 2024

VIA ELECTRONIC SUBMISSION — Regulations.gov

William N. Parham, III
Director, Division of Information Collections and Regulatory Impacts
Office of Strategic Operations and Regulatory Affairs
Centers for Medicare & Medicaid Services
7500 Security Boulevard
Baltimore, Maryland 21244

Re: CMS-10882. The Medicare Advantage and Prescription Drug Programs: Part C and Part D Medicare Prescription Payment Plan Model Documents

Dear Mr. Parham:

The Pharmaceutical Research and Manufacturers of America (PhRMA) appreciates the opportunity to comment on *The Medicare Advantage and Prescription Drug Programs: Part C and Part D Medicare Prescription Payment Plan Model Documents (CMS-10882)*.[1] PhRMA represents the country's leading innovative biopharmaceutical research companies, which are devoted to discovering and developing medicines that enable patients to live longer, healthier, and more productive lives. Over the last decade, PhRMA member companies have more than doubled their annual investment in the search for new treatments and cures, including nearly $101 billion in 2022 alone. Consistent with that mission, PhRMA companies are committed to the continued success of the Medicare Prescription Drug Benefit Program (Part D).

As reflected in several recent comment letters to the Centers for Medicare & Medicaid Services (CMS) on Part D redesign and the Medicare Prescription Payment Plan (M3P),[2] PhRMA supports successful implementation of the M3P program. This program, combined with an annual maximum OOP cap ($2,000 in 2025) in Part D, the $35 copay for covered insulins, and changes to the Extra Help Program[3] presents a unique opportunity to significantly improve affordability for some of the sickest and most vulnerable beneficiaries, especially those with multiple costly diseases and chronic conditions.

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[1] 89 Fed. Reg. 14847-48 (Feb. 29, 2024)
[2] https://phrma.org/-/media/Project/PhRMA/PhRMA-Org/PhRMA-Refresh/Report-PDFs/P-R/PhRMA-Comments-on-MPPP-Guidance_Final-92023.pdf; https://phrma.org/resource-center/Topics/Medicare/PhRMA-Comments-on-Medicare-Prescription-Payment-Plan-Draft-Part-Two-Guidance
[3] SSA § 1860D-2(b)(4)(B)(i)(VII).

While this comment letter is focused on specific model documents developed by CMS, we note that these documents represent just one part of the broader efforts that must be put in place to ensure successful implementation of the M3P program. As noted in our prior comments, a broad, robust education and outreach effort will be critical to ensuring that beneficiaries are made aware of this new payment option and are knowledgeable on how they may be impacted from election into the program, providing them the ability to make an informed decision on whether the M3P is right for them. Plan sponsors, pharmacies, patient navigators, and advocacy organizations will all play an important role in not only educating beneficiaries about the program, but also doing so in conjunction with CMS' efforts and guidance on the program. ***Therefore, it is crucial that CMS release its education and outreach materials and resources, such as updated Part D resources, CMS' educational product, a calculator tool, FAQs, etc., as soon as possible so that these stakeholders and other interested parties have sufficient time to amplify and incorporate this information in their own efforts to increase awareness about the program and ensure that the program is explained in a manner that is consistent with the language being utilized by the agency.*** Partnership with third party stakeholders, such as patient groups and senior organizations, will be an essential component to adequately educating beneficiaries about the program and reaching them where they are. To that end, we continue to encourage CMS to work closely with these interested parties and engage them on implementation of the program through a comprehensive education and outreach campaign as well as utilizing them as a resource as it pertains to receiving feedback about the direct impact of the M3P on beneficiaries. PhRMA has also recommended that CMS collect and evaluate data that will allow for the continual assessment of the likely to benefit threshold in order to determine whether the threshold is set at an appropriate dollar amount to where all or a significant percentage of beneficiaries who benefit from election into the program are effectively captured.

Our comments on this information collection request (ICR) address a number of elements across the model materials as a whole, as well as elements within specific materials that will be important in communicating with beneficiaries about the M3P.

General Comments

We appreciate CMS' efforts to create and release model materials for Part D sponsors to utilize in their communications with beneficiaries. However, we strongly encourage CMS to strengthen requirements for content standardization by plans. To ensure that all beneficiary notices are consistent across Part D plan sponsors, ***CMS should either require that all M3P notices be standardized, or at a minimum standardize the key content within each of the model materials if needed to accommodate plans that want to use their own branded materials.*** Standardizing these materials in their entirety, or key content within them, will be particularly important in the first year of M3P program implementation to avoid beneficiary confusion. It can also increase efficiency and simplify the plan outreach requirements set forth

by CMS, which may ease any potential burden to plan sponsors associated with developing their own notices and materials.

Additionally, accessibility and readability of these materials are paramount to ensuring beneficiaries understand the information provided to them and are able to take any appropriate next steps. ***Given the full name of M3P includes the term "Plan", we encourage CMS to be very clear in all these materials that the materials relate to the M3P only, to limit any beneficiary confusion that these notices relate to their Part D plan. This is particularly important for the "Missed Payment" and "Termination" notices.*** For example, using language that refers to the program as a "payment option" instead of a "plan" may aid in this effort. We also recommend that CMS use plain language across all the model materials to ensure that beneficiaries across all populations understand the documents. This effort includes taking steps to make these materials are available across multiple languages and are culturally relevant to non-English speaking populations as well as in formats that are accessible to beneficiaries with disabilities. We emphasize the importance of these actions given that the M3P is a brand-new payment option for beneficiaries with the opportunity to increase affordability of medications for a significant number of beneficiaries. It is therefore necessary that all program materials, provided by CMS and plan sponsors, are developed with this need for accessibility and comprehensibility in mind to ensure that all beneficiaries regardless of background or level of literacy can effectively engage with the M3P to suit their individual needs. Additionally, time permitting, we encourage CMS to consumer-test these materials to ensure they are effectively communicating potential benefits and features of the M3P program.

Likely to Benefit Notice: "Consider Managing Your Monthly Costs with the Medicare Prescription Payment Plan"

As mentioned in our prior comments, we commend CMS for requiring standardization of the Likely to Benefit Notice to promote consistency in information provided to beneficiaries when they are first notified prior to the plan year or during the plan year that they may benefit from election into the program.[4] However, we are concerned that the Likely to Benefit Notice fails to clearly convey the actual benefits that are likely to accrue to beneficiaries with high OOP costs. Since this notice may be the first time a beneficiary is introduced to the M3P, ***PhRMA recommends that CMS provide additional clear, concise information that more effectively conveys why and how beneficiaries are likely to benefit from the program, and ensure key details of the M3P are communicated in a manner that is easily understood by beneficiaries, including more detail in the sections outlining the next steps a beneficiary could take to sign up, and additional resources they could access (e.g., at CMS) to learn more about the program.*** While we understand that CMS wants to ensure beneficiaries are fully educated about

[4] https://phrma.org/resource-center/Topics/Medicare/PhRMA-Comments-on-Medicare-Prescription-Payment-Plan-Draft-Part-Two-Guidance

the program, many of the clauses CMS draws attention to with bolded text negatively frame the program. Because those who receive the notice are most likely to benefit based on the CMS established thresholds, CMS should include accurate information but also carefully balance the tone so this notice doesn't serve to discourage beneficiaries from learning more about the program and/or election. Specific recommendations include:

- Introduction paragraph: There should be a brief explanation in the introduction paragraph about why the beneficiary is receiving this notice (e.g., a beneficiary has hit $2,000 out of pocket prior to the start of the plan year or $600 out of pocket with a single prescription during the plan year), and why they may benefit from the program. In addition, the language "that vary throughout the year" is unnecessarily discouraging and may be confusing for the introduction paragraph. While accurate, that content is already included in the "how will my costs work" section.
- Will this payment option help me?: Language focused on how beneficiaries can "manage" monthly drug costs, stressing that monthly costs may vary, and noting that the program "doesn't save you money," while technically accurate, could confuse beneficiaries and lead them to believe there is no benefit to a program from which they have been identified as "likely to benefit." It may also be helpful to clearly state in this notice that beneficiaries can expect to receive two separate bills (i.e., one for payments under the program and another for their Part D plan premiums), and to describe the ways they may benefit from it (e.g., by spreading costs out over several months, it may help them reduce OOP costs in the initial months of the program compared to what they would have otherwise paid). Additionally, CMS should include language that directs beneficiaries to any CMS developed educational materials or resources about the program, such as a calculator tool, example calculations, and additional information about the program.
- How do I know if this payment option might not be right for me?: We recommend that CMS split this list into two subsections. One for situations where a beneficiary would not benefit from election into the program, such as those with low-income subsidy or who qualify for a Medicare Savings Program, along with a brief explanation as to why they would not benefit (i.e., under these assistance programs, they already have low, consistent out of pocket costs). Then another subsection for the remaining instances where a Medicare beneficiary may not benefit from program, with direction for those individuals to call their plan or 1-800-Medicare for counseling on whether they should elect into the program.
- How do I sign up for this payment option?: We suggest that CMS add more detailed language about what immediate next steps a beneficiary could take should they want to elect into the program to make their prescription OOP costs

more affordable (e.g., provide the timeline for acceptance into the program by the plan and make it clear that the beneficiary can return to the pharmacy counter to pick up their medication). This gives beneficiaries actionable steps they can take upon receiving this notice and may ease any concerns about still being able to access their medication once they take the steps to elect into the program.

Medicare Prescription Payment Plan Participant Request Form

Regarding the Participant Request Form, we recommend the following changes:

- Add a brief description about the M3P to the top of the form as a reminder of why the beneficiary is filling out the form;
- Add a placeholder for the plan's phone number in the section for the plan's information in the event a beneficiary may need assistance while filling out the form;
- Provide a clear header to the section of the form that is meant to be filled out by an authorized representative of the beneficiary.

In addition to the above recommendations, we suggest that CMS provide guidelines for plans around the terms and conditions that plans can place at the end of the form, to ensure clarity on content and that there are no onerous terms related to the program being added to the form by plans.

Exhibit 1 - Part D Sponsor Notice to Acknowledge Acceptance of Election in the Medicare Prescription Payment Plan

In the Notice of Acceptance, it will be important to provide the beneficiary with any pertinent information about their participation in the program at the outset so they can be made aware of some of these nuances or key aspects of the program. Therefore, we recommend that CMS add more detailed language to the notice in the following sections:

- What happens if I don't pay my bill?: We suggest adding that a beneficiary can be reinstated in the program if they repay any owed amounts to their plan. It is important for the beneficiary to know there is a path to re-elect into the program and what they need to do in order to accomplish that, should they be terminated from M3P for missing a payment.
- Can I leave the Medicare Prescription Payment Plan?: We encourage CMS to add language notifying the beneficiary that they must elect into the program each year should they want to continue their participation. This would aid in continuous participation in the program from year to year and prevent any confusion should a beneficiary assume that their participation in the program

automatically rolls over into the following year. Given CMS discusses switching plans in this section, it would also be helpful to note that if a beneficiary switches plans, they still owe their previous plan any unpaid amounts that were incurred during their participation in the program.

Exhibits 2 & 3 – Part D Sponsor Initial Notice for Failure to Make Payments under the Medicare Prescription Payment Plan & Notification of Termination of Participation in the Medicare Prescription Payment Plan

As mentioned previously in this letter, clarity when discussing the M3P as it relates to various aspects of the program within materials utilized for communication is crucial. This is even more pertinent for these two notices as they deal with missed payments and termination from the program. Therefore, PhRMA recommends that CMS use language in these notices that clearly refers to the M3P itself and refrains from using terms that could be interpreted as applying to Part D plans. This could help lessen possible beneficiary confusion or concerns that the notice they receive is referring to a missed payment or termination from their Part D plan.

Additionally, we recommend that CMS include more concise and clearer language about reinstatement into the M3P program. This way, beneficiaries are made aware that there is an opportunity to re-elect into the program upon receipt of either of these notices, should they choose to do so. This language should describe the steps needed in order to be able to re-elect into the program, such as repaying costs owed to the plan from their participation in the M3P. It would also be beneficial to include information about the "good cause" allowances within the notices, or at a minimum inform beneficiaries about the existence of the policy and direct them to a resource should they want to learn more about it. Beneficiaries should be made aware of the protections that exist for them under the M3P, so they can have the knowledge to pursue proper recourse should it be necessary.

Exhibit 4 – Part D Sponsor Notification of Voluntary Removal from the Medicare Prescription Payment Plan

PhRMA appreciates that CMS has developed a separate notice for voluntary termination, as this form of termination is significantly different from plan actions to remove an individual from M3P due to missed payments. However, there may be instances where a beneficiary voluntarily terminates from the program that are distinctly different and may require additional information to what is currently provided in CMS' "Voluntary Termination" notice. For example, a beneficiary who switches plans and a beneficiary who chooses to end their participation in the program may both count as voluntary termination from M3P. However, a beneficiary switching plans may require additional information, such as reminder they must re-elect under their new plan if they wish to continue their participation in the program and that there may still be

payments owed to their former plan for costs incurred during their participation in the program. Therefore, we recommend that CMS either add language to provide clarity for these differing instances of voluntary termination or consider the creation of supplemental materials, such as FAQs, to provide additional information about various beneficiary scenarios.

* * * *

PhRMA appreciates the opportunity to provide feedback on the Medicare Prescription Payment Plan Model Documents ICR. We look forward to opportunities for continued collaboration with CMS in implementing the M3P, which is an important beneficiary affordability improvement in Part D. As noted earlier, finalizing content of these model documents is just one piece of the broader efforts on implementation of the M3P program. To that end, we want to encourage CMS to also move forward with its larger efforts related to education and outreach on the program. We are happy to discuss these comments and provide any further details or supplemental materials that you may request.

Sincerely,

Rebecca Jones Hunt

Deputy Vice President, Policy & Research

/s/

Judy Haron

Deputy Vice President, Law

Kristin Williams

Senior Manager, Policy & Research

April 29, 2024

Filed electronically via federal eRulemaking Portal: www.regulations.gov

Ms. Chiquita Brooks-LaSure
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Mr. William N. Parham, III
Director, Paperwork Reduction Staff,
Office of Strategic Operations & Regulatory Affairs
U.S. Centers for Medicare & Medicaid Services
750 Security Boulevard
Baltimore, MD 21244

RE: The Medicare Advantage and Prescription Drug Programs: Part C and Part D Medicare Prescription Payment Plan Model Documents (CMS-10882)

Dear Administrator Brooks-LaSure and Director Parham:

The Pharmaceutical Care Management Association (PCMA) appreciates the opportunity to provide public comments on the U.S. Centers for Medicare & Medicaid Services' (CMS) Medicare Prescription Payment Plan (referred to as M3P or Program) Model Documents (Model Documents),[1] issued for comment pursuant to a Paperwork Reduction Act Notice published by CMS in the *Federal Register* on February 29, 2024.[2]

PCMA is the national association representing America's pharmacy benefit managers (PBMs), which administer prescription drug plans and operate specialty pharmacies for more than 275 million Americans with health coverage through Fortune 500 companies, health insurers, labor unions, Medicare, Medicaid, the Federal Employees Health Benefits Program, and through the exchanges established by the Affordable Care Act. Our members are committed to increasing affordability of drugs and work closely with plans and issuers to secure lower costs for prescription drugs and achieve better health outcomes.

A. General Comments

We appreciate CMS creating the Model Documents to assist Part D sponsors in meeting their educational and outreach responsibilities regarding M3P as required by Sections 1860D-2(b)(2)(E)(v)(II) – (IV) of the Social Security Act (the Act). Given the complexity of the Program, the significant time and resources that will be required for Part D sponsors to implement it, and the fact that communications and outreach must begin in the fourth quarter of 2024 for the 2025 plan year (CY2025), we ask that CMS make every effort to finalize the Model Documents as soon as possible and no later than June 2024. This is essential to allow Part D sponsors sufficient time to develop, finalize, and produce their Program's materials.

[1] The Model Documents are available at https://www.cms.gov/medicare/regulations-guidance/legislation/paperwork-reduction-act-1995/pra-listing/cms-10882.
[2] 89 Fed. Reg. 14847 (February 29, 2024).

***PCMA recommendation*: CMS should finalize and publish the Model Documents by June 2024 in order to allow Part D sponsors sufficient time to incorporate these into their CY2025 Program's materials that they will start disseminated in the fall of 2024.**

Implementing a program as complex and multi-faceted as M3P would be challenging at any time but will be particularly so in 2025 when it will be rolled out simultaneously with major changes in the Part D benefit itself. This is especially the case as some of the most significant changes in the Part D program relate to true out-of-pocket costs (TrOOP), which in turn directly affect enrollee out-of-pocket (OOP) costs under M3P. In light of this, and to avoid beneficiary confusion as much as possible, it is imperative that the Program's materials, including the Model Documents, be as clear, simple, and easy-to-understand as possible. Communications that extend beyond a single page are much less likely to be read by beneficiaries and, therefore, will defeat the purpose of the communication. We therefore encourage CMS to keep explanations concise and tailored to the circumstances and nature of the communication in question, with additional detail available from CMS and Part D sponsors' websites.

***PCMA recommendation*: CMS should prioritize providing clear, concise, and easy-to-understand communications about the Program to limit beneficiary confusion and improve beneficiary satisfaction with the Program.**

We also ask that CMS consider alternative ways for Part D enrollees to receive information in an easy-to-understand manner, such as YouTube and Facebook videos. All educational materials (written/videos/websites) should be targeted to all literacy levels and should be focus group tested for ease of comprehension.

***PCMA recommendation*: CMS should use alternative ways to reach out to Part D beneficiaries about the Program, such as through social media websites and videos.**

B. Specific Comments

Below we include comments on a number of the Program's model documents.

1. Election Request Form

We recommend adding the following instruction prior to the cells for representative information:

Complete the following section ONLY if the person making this request is not the enrollee.

Alternately, the form could be modified as follows, which would be clearer and support signature by a legal representative:

2) Documentation of this authority is available upon request by Medicare.	
Signature:	**Today's date:**
If you're the authorized representative, sign above and fill out these fields:	
Name:	Address:
Phone number:	Relationship to enrollee:

2. Likely to Benefit Notice

We have the following recommendations on this Model Document:

- Lower the readability level so that it is easier for enrollees to understand. This is particularly important for this notice as it is the key document explaining what the Program is and how it works.
- Delete the reference to "January-December" in the first paragraph and instead state "throughout the months remaining in the plan year." This will avoid confusion for enrollees who receive the notice during the plan year.
- Replace "Medicare drug plans and Medicare health plans with drug coverage (like a Medicare Advantage Plan)" with simpler language such as 'all Medicare plans with drug coverage' or other similar simplified language. We appreciate that the proposed language is technically precise but are concerned that it will be confusing for enrollees.
- Include examples and/or a link to a QR code to simplify the process for enrollees. Recommend adding examples in the document or a link or QR code to simplify the process for the enrollee in response to the question "How will my costs work with this payment option?"
- Add "You have $0 cost share/copay prescription drugs" as one of the scenarios listed under the "How do I know if this payment option might not be right for me?" section. This will be especially helpful for members of Dual Eligible Special Needs Plans (D-SNPs) or for Low-Income Subsidy (LIS) enrollees who have zero cost sharing.
- The Likely to Benefit notice should specify that M3P might not be right for those with $0 cost share/copay prescription drugs.

In addition, a separate, much shorter Likely to Benefit notice should be created for pharmacies to provide when an enrollee's out-of-pocket on a Part D claim meets or exceeds the $600 threshold. For example, the form could contain the following language:

> *"You may be likely to benefit from the Medicare Prescription Payment plan due to high-cost Part D medications. This payment plan allows you to spread the cost of any additional medications over the remainder of the plan year. Please visit your plan's website or contact your plan at the number on your ID card for more information."*

3. Notice of Election Approval

We have the following comments on this Model Document:

- In response to the question: "Can I leave the Medicare Prescription Payment Plan," the participant is given only the option to call to opt out. However, the draft Part Two guidance does not limit the mechanism for voluntary terminations to only phone calls, and plans provide for other mechanisms to do so. Accordingly, the model document should accommodate other mechanisms.
- In response to the question "Are there other programs that can lower my costs?" the document should include a hyperlink to secure.ssa.gov/i1020/start in the "Extra Help" paragraph so that enrollees can link with the online version.

PCMA

4. Notice of Failure to Pay

We have the following recommendations on this Model Document:

- In response to the question: "What if I can't afford to pay both my plan premium and my Medicare Prescription Payment Plan payment," the participant is told that an M3P payment can be applied to their premium if they like. However, in most cases, the responsibility for managing the Program will be delegated to the plan's PBM or other external vendors that provide for an address/avenue for submission of the M3P payment that is separate from the premium's payment to the plan. The proposed language will require the PBM/vendor to coordinate with the plan to apply a Program's payment to premiums, which introduces further complexities and potential for error. We request CMS remove this section from the Notice since it is not a requirement in the draft M3P Part Two guidance.

5. Notice of Involuntary Termination

Instead of referring to the Program as a "payment option" in the question: "Can I use this payment option in the future," we recommend it state "Can I rejoin this program/the Medicare Prescription Payment Plan in the future?" The use of 'payment option' may be confusing for enrollees.

* * *

We appreciate the opportunity to provide this feedback to CMS on the M3P Model Documents, which will play a critical role in explaining the Program to beneficiaries. Our recommendations focus on ways to make the communications as clear, simple, and beneficiary-friendly as possible, since this will be essential to avoid beneficiary confusion and ensure the success of the Program. If you need any additional information, please reach out to me at tdube@pcmanet.org.

Sincerely,

Tim Dube

Tim Dube
Senior Vice President, Policy & Regulatory Insights

cc: Debjani Mukherjee, Senior Director, Regulatory Affairs

Submitted Electronically

April 29, 2024

The Honorable Chiquita Brooks-LaSure
Administrator
Centers for Medicare & Medicaid Services
7500 Security Boulevard
Baltimore, MD 21244

RE: The Medicare Advantage and Prescription Drug Programs: Part C and Part D Medicare Prescription Payment Plan Model Documents (CMS-10882)

Dear Administrator Brooks-LaSure,

The Protecting Innovation in Rare Cancers (PIRC) coalition appreciates the opportunity to submit feedback, including input from our patient communities, on the six model documents created as part of the Centers for Medicare & Medicaid Services' (CMS') implementation of the Part D Medicare Prescription Payment Plan (MPPP). We especially appreciate that CMS not only sought public comment on these important documents, but that it provided sufficient time for advocacy organizations like those within the PIRC coalition to collect feedback from actual patients who will need to understand the documents to fully benefit from the MPPP.

PIRC is a collaborative, multi-stakeholder, patient advocacy coalition focused on improving access to and affordability of existing treatments while preserving the incentives required to advance future innovations in rare cancers. The coalition seeks to fulfill an important role in exchanging information and collaborating toward educating both our rare cancer communities

and policymakers on the impact the Inflation Reduction Act (IRA) might have on access to existing Part D drugs and development of new therapeutic options.

Cancer patients can face significant challenges in affording their prescribed treatments. Since rare cancer patients typically have fewer effective therapeutic options, unaffordable out-of-pocket costs can be catastrophic. The CLL Society, for example, noted that for patients with chronic lymphocytic leukemia/small lymphocytic lymphoma (CLL/SLL) targeted therapies such as BTK inhibitors and the BCL2 inhibitor known as venetoclax offer substantial efficacy and have transformed care for its patient community. These patients now have more treatment options compared to just years ago when the standard of care was chemoimmunotherapy. BTK inhibitors are covered under the Medicare Part D benefit and offer patients an effective, oral treatment that has become, for many, the standard of care in first-line therapy. Unfortunately, the historically high out-of-pocket costs have kept this option out of reach for far too many patients. The IRA's enactment of a more affordable Part D out-of-pocket cap, combined with enabling Part D enrollees to spread their out-of-pocket costs over the plan year by opting into the MPPP will make a real difference for CLL/SLL and other rare cancer patients relying on Medicare coverage in their fight against cancer.

We appreciate that CMS continues to work on ensuring smooth, timely implementation of the MPPP. The six model notices are a critical part of successful MPPP implementation as they will be disseminated to Part D enrollees considering or actively participating in the MPPP.

As noted above, we have reached out to our patient communities and asked that they review the documents to identify any language that is confusing or unclear as well as gaps between the information contained in the notices and the information patients might need. The feedback PIRC received on the model documents is outlined below:

Document 1: Likely to Benefit Notice ("Consider Managing Your Monthly Drug Costs with the Medicare Prescription Payment Plan")

PIRC agrees that increased outreach and education efforts targeted toward individuals most likely to benefit from the MPPP will be essential to program success, especially in its initial years. We appreciate that CMS seeks to provide these individuals with multiple, meaningful opportunities to review program materials and opt into participation. We support CMS'

requirement that plans review enrollee prescription drug expenditures for previous plan years and target outreach to their enrollees with historically high out-of-pocket costs.
We also agree that the later a beneficiary opts into the Program, the less likely they are to benefit from participation. These individuals may, however, benefit from opting in for the next plan year and, for beneficiaries meeting the "likely to benefit" criteria in the fourth quarter, we urge CMS to require that plans give these individuals an opportunity to opt in for either/both the current and next plan year.

PIRC understands that the Likely to Benefit Notice is packed with information intended to help Medicare beneficiaries decide whether the MPPP would ease the financial burden associated with their prescription drugs. Unfortunately, several patients found that the document was "densely packed" and unclear with respect to the potential benefits of participation.

- The Cutaneous Lymphoma Foundation suggested that the information be presented in bullet point format rather than as paragraphs so that individuals can easily see any steps required to opt into the MPPP.

- CLL/SLL patients noted that based on the relatively high cost of their rare cancer treatment, the $2000 out of pocket cap would be reached in January. There was no explanation of why the $2000 would not be divided evenly over 12 months if the individual opts in before the start of the plan year.

- For individuals likely to hit the out-of-pocket maximum more slowly, the premise that new prescriptions would lead to increased monthly payments makes sense.

- The statement that "[y]ou'll never pay any interest or fees on the amount you owe, even if your payment is late" does not tell the full story, i.e., that individuals failing to make payments would not be eligible to participate in the MPPP with their existing plan until overdue payments are paid. That information is provided after individuals opt into participation and should also be presented during the decision process.

    - One patient suggested that specifying that late payments do not result in additional fees or interest "just encourages folks not to make timely payments."

    - Another patient expressed concerns that the default rate under the MPPP could impact Part D premiums as well as the number of Part D sponsors continuing to offer Part D plan choices.

- The ability to make monthly payments is a good option and it would be helpful to let patients know how they would be making those payments to their plan. For example, one CLL patient noted that the Veterans Administration administers a copayment plan that allows participants to have payments automatically made each month through their bank account. Rare cancer patients, particularly those within the Medicare beneficiary population, may find it easier to have an automatic payment option so that they do not have the additional stress of looking out for and paying their MPPP bill each month.

- Patients reviewing this document were concerned that there was no clear information on whether and how an individual could exit the MPPP and go back to paying at the pharmacy counter. Again, while this information is given to individuals after they opt in, it is an important element of the MPPP that individuals should understand as they decide whether MPPP participation is right for them.

- Several patients and organizations suggested that a set of hypothetical scenarios would clarify how monthly payments are calculated. These examples should include:

    - A scenario detailing monthly payments for a patient who incurs drug expenses exceeding the out-of-pocket cap in January (or the first month of the plan year).
    - A scenario with more evenly spread costs that exceed the cap during the first three or four months of the year.
    - A scenario with high-cost drugs purchased in the last quarter of the plan year.

Without examples, Medicare beneficiaries are likely to find the MPPP confusing and even risky.

- Making an analogy between the MPPP and, for example, a consumer installment plan would help Medicare beneficiaries understand what the program is and how it works. In

simple terms, the MPPP is an installment plan without interest, and Medicare beneficiaries are likely able to understand this analogy.

- A simplified "Frequently Asked Questions" (FAQ) document, accompanying the various MPPP forms would help individuals find the information they need and reduce confusion.

- The Likely to Benefit Notice should also clarify that pharmacies, including mail order pharmacies, will be required to dispense medications to MPPP participants – several individuals were concerned that their pharmacy might delay or decline to fill prescriptions if they did not pay at the pharmacy counter.

- The model form outlined a set of scenarios that might make an individual unsuitable for MPPP participation. Several CLL/SLL patients noted that the list Included the example of individuals with consistent monthly drug costs over the plan year. This could give CLL patients relying on BTK inhibitors and other rare cancer patients prescribed oral treatments the impression that they should not opt into the MPPP even though they have out-of-pocket costs exceeding $2000 during the first month of the year. CMS should clarify or remove this example.

Document 2: Election Request Form ("Medicare Prescription Payment Plan participation request form")

Most individuals found that the Election Request Form was "straightforward and clear." Several others expressed concerns that potential participants would need more information and greater clarity on when their participation would take effect. Additional feedback included:

- CMS should develop model language for the "terms and conditions" for plans and participants. That language should be simple and included with the Election Request Form so that Medicare beneficiaries understand their rights and responsibilities. Permitting each plan or sponsor to develop their own sets of terms and conditions would invite inconsistencies across the MPPP.

- The election form does not provide information on the timeframe required for the plan to process the election request, reasons a plan might have for denying the request, or what communications the individual should expect. This could lead to confusion and delays if, for example, the plan fails to receive and process the individual's election to participate in the MPPP.

- It is unclear whether the individual will have additional documents to execute and/or potential inquiries from the plan.

- Opting in by mailing the Election Form is not the only election mechanism plans are required to offer. The election form should provide information on alternative ways to opt in and outline the processing time associated with each mechanism.

- The phone number field should specify that the plan is requesting the phone number for which communications between the plan and participant can be made. If the plan intends to send text messages to participants, it should enable participants to opt in on text messages if they provide a mobile phone number.

- Medicare beneficiaries may be uncomfortable submitting a form with their full Medicare number through the mail or online due to privacy and identity theft concerns. We urge CMS to work with plans on alternative way of accurately identifying participants such as the last four digits of a beneficiaries Medicare number.

Document 3: Notice of Election Approval ("Part D Sponsor Notice to Acknowledge Acceptance of Election to the Medicare Prescription Payment Plan")

The Notice of Election Approval lacks details individuals may need to ensure that they are able to comply with MPPP requirements. It also contains information that rare cancer patients would find helpful before opting into the MPPP (i.e., within the Notice of Likely Benefit or the Election Form).

- The Likely to Benefit document should include language similar to statements within the Notice of Election Approval reassuring individuals that plans will notify pharmacies of their participation in the MPPP. This would resolve concerns that prescription fills could

be delayed or denied if patients decline to pay their out-of-pocket costs at the pharmacy counter.

- Several rare cancer patients indicated that they were uncertain of whether plans would simply inform pharmacies that had filled previous prescriptions of their participation in the MPPP. Many individuals with CLL/SLL also mentioned that they receive their medications from multiple pharmacies and were concerned that the document seemed to indicate that their MPPP participation would not be fully linked with their plan information and available to ***all*** pharmacies.

- The documentation should clarify that MPPP plan participant maximum total payment would be the cost associated with the drugs they obtain during their participation minus any amounts paid during the plan year at the pharmacy counter.

- Beneficiaries reading this document might assume that if they remain in their Part D plan year after year, their participation in the MPPP will also continue until they terminate it. If that is not the case, the document should make it clear that participants must opt in each year.

- It would be helpful if plans provide a mechanism for voluntary termination from MPPP participation other than through a telephone conversation with a live customer service representative (e.g., through the plan's website). Telephone-based voluntary termination should include an option to call during or outside office hours and access a menu that would enable termination without reaching a live customer service representative. A confirmation number after verification that the participant seeks to terminate their MPPP would provide a level of comfort that the termination was effective.

- A brief sentence summarizing the information in this document on voluntary and involuntary termination should be included in the Likely to Benefit document.

Document 4: Notice of Failure to Pay ("Part D Sponsor Notice for Failure to Make Payments under Medicare Prescription Payment Plan")

PIRC appreciates that the Notice of Failure to Pay clearly informs individuals that their enrollment in the Part D plan is not impacted by their failure to pay. We also appreciate that the document encourages plans to permit partial payments to enable participants to continue in the MPPP. Rare Cancer patients reviewing this document expressed that:

- The time between the payment due date and issuance of this notice is not clear. CMS should provide guidance or instructions to plans on when to notify participants that they have not made a timely payment.

- The Notice states that "[a]s of <effective date>, you'll pay the pharmacy directly for your out-of-pocket drug costs." This statement should be revised to clarify that responsibility will be limited to ***remaining*** out-of-pocket costs to reinforce beneficiary out-of-pocket is $2000 and includes paid and unpaid balances under the MPPP even if the individual is terminated.

Document 5: Notice of Involuntary Termination ("Part D Sponsor Notice for Failure to Make Payments under Medicare Prescription Payment Plan – Notification of Termination of Participation in the Medicare Prescription Payment Plan")

While virtually all patients reviewing this document found that it was clear and understandable, several patients expressed concern that there was no stated mechanism for participants to continue working with the plan to get current and resume participation.

We urge CMS to make a revision to this document clarifying that termination does not change the beneficiary's maximum out-of-pocket obligation and that their payments at the pharmacy counter will be limited to the amount needed to reach that $2000 maximum. It is likely that beneficiaries who, for example, have $1000 remaining unpaid balance under the MPPP and are terminated could believe that they will pay that $1000 again at the pharmacy counter.

Finally, although PIRC has some concern that widespread MPPP defaults followed by defaulting individuals switching to a different plan and enrolling in that plan's MPPP would be a destabilizing force, we believe that beneficiaries should have clear information accurately reflecting the statutory language enacting the MPPP. The section stating that participants can only resume MPPP participation after paying any amounts due should be qualified to reflect

that the "ban" on participation is for that Part D sponsor. We suggest that the question "**Can I use this payment option in the future?"** be answered with "You may enroll in a [plan/issuer] payment plan once you pay the total amount you owe."

Document 6: Notice of Voluntary Termination ("Part D Sponsor Notification of Voluntary Removal from the Medicare Prescription Payment Plan")

The information in the Notice of Voluntary Termination was, for rare cancer patients, generally viewed as straightforward, complete, and clear. We did receive feedback that:

- The document should reinforce, in clear, bold type, that the individual MUST continue to pay their Part D premium each month.

- There may be a tendency for some individuals to decline to pay remaining balances after they voluntarily terminate from the MPPP. Patients are uncertain of what, if any, impact widespread nonpayment under the MPPP might have on their future premiums and plan options (if Part D sponsors face financial risk under the MPPP).

Additional Comments and Feedback

Overall, rare cancer patients expressed appreciation for the content throughout the series of documents reiterating that there are various payment options, that not participating in the MPPP in no way impacts the patients' Part D costs, and that there are programs that might help lower costs. This information was very clear and viewed as helpful for Medicare beneficiaries.

PIRC also appreciates that CMS intends to require that plans include MPPP information on their websites as well as within the Part D materials currently furnished to enrollees, including mailings of membership ID cards, explanation of benefits (EOB), Annual Notice of Change (ANOC), and Evidence of Coverage (EOC) documents. We remain concerned that the routine nature of these mailings might increase the likelihood that enrollees will overlook important information on Program availability and opt-in mechanisms and strongly recommend that CMS require plans to make this "new" information conspicuous by including notification language on the envelope where it can easily be seen as well as on the first page of any document(s). We also urge CMS to create "model" language for these information sources.

We are similarly concerned that CMS has not outlined its plan to adapt the content of the model documents to meet the needs of non-English speaking beneficiaries and those with disabilities. We urge the Agency to consider developing a set of informational videos with guidance in several languages, including American Sign Language (ASE) and to provide the model documents in Braille, large print, and in formats compatible with screen readers and other accessibility tools.

Finally, PIRC appreciates that CMS has emphasized the need for informational uniformity and clarity through multiple messaging channels in crafting Part D plan outreach and education requirements. We agree that CMS-created model notices, forms, and beneficiary communications will be crucial to effective outreach and support CMS' decision to require that plans use the model documents.

Conclusion

Once again, the undersigned organizations appreciate the opportunity to comment on CMS' set of model documents in connection with the MPPP. We look forward to continuing to work with you in ensuring that all Medicare beneficiaries, including those with rare cancers, can receive the treatments they need without financial hardships associated with high out-of-pocket costs.

If you have any questions or would like additional information, please contact Carly Boos at cboos@cllsociety.org.

Sincerely,
Amyloidosis Foundation
Association of Cancer Care Centers
Biomarker Collaborative
Cancer*Care*
Cancer Support Community
Chondrosarcoma CS Foundation, Inc
Cutaneous Lymphoma Foundation
Exon 20 Group
Hairy Cell Leukemia Foundation

ICAN, International Cancer Advocacy Network
International Myeloma Foundation
International Waldenstrom's Macroglobulinemia Foundation
MDS Foundation
MET Crusaders
Ovarian Cancer Research Alliance
PD-L1 Amplifieds
PTEN Hamartoma Tumor Syndrome Foundation
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April 29, 2024

William Parham, III
Director, Paperwork Reduction Staff
Office of Strategic Operations and Regulatory Affairs
Centers for Medicare & Medicaid Services
7500 Security Boulevard
Baltimore, MD 21244

Re: CMS-10882 The Medicare Advantage and Prescription Drug Programs: Part C and Part D Medicare Prescription Payment Plan Model Documents

Dear Director Parham:

I appreciate the opportunity to provide feedback on the Medicare Advantage and Prescription Drug Programs: Part C and Part D Medicare Prescription Payment Plan Model Documents.

I am a Senior Vice President at Segal. Segal is an employee benefits, compensation and human resources consulting firm, with more than 1,000 employees throughout the U.S. and in Canada. Segal provides actuarial and consulting services to employee benefit plan sponsors who provide retiree health benefits through their own plan, often receiving the Retiree Drug Subsidy, or through an Employer Group Waiver Plan (EGWP).

EGWP Plans and the M3P Notices

CMS has determined that the M3P program applies to Employer Group Waiver Plans (EGWPs). It has also published standard notices for informing beneficiaries of the M3P program, including the "Likely to Benefit" notice. The "Likely to Benefit" notice provides information on the M3P program, the reason the beneficiary is receiving the notice, whether the beneficiary will benefit from the program, and how to elect the program. CMS has also stated it will provide additional guidance on more general information about the program to be made available by plans to beneficiaries, for example on plan websites.

EGWPs usually provide extremely generous prescription drug benefits which are tailored to reflect the employee benefits retirees received throughout their working career. Many programs have very low copayments for prescription drugs, resulting in low cost sharing paid by retirees participating in the EGWP. EGWP plan sponsors currently have the ability to customize beneficiary communications to assure that the communications accurately convey the benefits available under the EGWP plan. This often means customizing standard language used by non-EGWP Part D plans.

It will be important for EGWP plan sponsors to customize notices, including the "Likely to Benefit" notice, for their particular beneficiary populations. EGWPs should be able to assure

that their notices are consistent with other beneficiary communications and with the plan's benefit design. EGWPs should be able to include examples of benefit payments to illustrate when individuals would have costs that would benefit from the M3P program, and when they would not benefit. EGWP plan sponsors should be able to fully describe the differences between their current cost sharing structure and the new monthly payment structure in a manner that is understandable to their population. The "Likely to Benefit" notice does not currently permit examples of the impact of the program on the EGWP participant.

Additionally, the "Likely to Benefit" notice states when the payment option might not be "right for me". However, it does not include EGWP membership as a potential category of individuals who may not benefit from the M3P program because they already have significantly lower cost-sharing than in a commercial Part D plan.

Finally, it is important to the ability of employer sponsored plans to offer EGWP programs to be able to assure that only those beneficiaries who would benefit from the program elect it, and to be able to fully describe the individual details of their plan and the impact on cost sharing. It is in the interest of the plan participants to receive as much information as possible in the "Likely to Benefit" notice, and in general communications about the program, so that participants can make an educated selection about whether to participate.

Thank you for the opportunity to comment on these notices. Please feel free to contact me if you have any questions.

Sincerely,

Kathryn Bakich

Kathryn Bakich
Senior Vice President

April 26, 2024

UCare is submitting the attached comments regarding Document Identifier: CMS–10882. As part of our comment collection for the Part C and Part D Medicare Prescription Payment Plan model documents, UCare met with a group of our Medicare members to review the *Medicare Prescription Payment Plan Likely to Benefit Notice* and *Part D Sponsor Initial Notice for Failure to Make Payments under the Medicare Prescription Payment Plan*.

We have provided our members' comments in addition to our internal comments for the notices above.

Sincerely,

UCare
Government Relations

500 Stinson Blvd NE, Minneapolis, MN 55413 | 612-676-6500 | fax 612-676-6501 | **ucare.org**

Consider Managing Your Monthly Drug Costs with the Medicare Prescription Payment Plan

You might benefit from participating in the Medicare Prescription Payment Plan, because you have high drug costs. This new payment option works with your current drug coverage, and it can help you manage your drug costs by spreading them across **monthly payments that vary throughout the year** (January – December).

What's the Medicare Prescription Payment Plan?

The Medicare Prescription Payment Plan is a new payment option to help you manage your out-of-pocket drug costs, starting in 2025. All Medicare drug plans and Medicare health plans with drug coverage (like a Medicare Advantage Plan) must offer this payment option, and all plans use the same formula to calculate your monthly payments. If you select this payment option, each month you'll pay your plan premium (if you have one) and you'll get a bill from your health or drug plan for your prescription drugs (instead of paying the pharmacy).

Participating in this payment option is voluntary. Anyone with a Medicare drug plan or a Medicare health plan with drug coverage can use this payment option, which applies to all prescription drugs covered by Part D. It doesn't cost anything to participate in the Medicare Prescription Payment Plan, and you won't pay any interest or fees on the amount you owe, even if your payment is late.

Will this payment option help me?

It depends on your situation. If you have high out-of-pocket drug costs, this payment option spreads out what you'll pay each month across the year (January – December), so you don't have to pay out-of-pocket costs to the pharmacy. **This payment option might help you manage your expenses, but it doesn't save you money or lower your drug costs.** Visit Medicare.gov/basics/costs/help/drug-costs to learn about programs that can help lower your drug costs.

How will my costs work with this payment option?

The new prescription drug law caps your out-of-pocket costs at $2,000 in 2025 and eliminates the coverage gap (known as the "donut hole"). This means you'll never pay more than $2,000 in out-of-pocket drug costs in 2025. **This is true for everyone with Medicare drug coverage, even if you don't join the Medicare Prescription Payment Plan.**

When you fill a prescription for a drug covered by Part D, you won't pay your pharmacy (including mail-order and specialty pharmacies). Instead, you'll get a bill each month from your plan. Your monthly bill is based on what you owe for any prescriptions you get, plus your previous month's balance, divided by the number of months left in the year.

Note: Your payments might change every month, so you might not know what your exact bill will be ahead of time. Future payments might increase when you fill a new prescription or refill an existing prescription because as new out-of-pocket drug costs are added into your monthly payment, there are fewer months left in the year to spread out your payments.

How do I know if this payment option might not be right for me?

This payment option might not be helpful for you if:

- You get Extra Help from Medicare.
- You qualify for a Medicare Savings Program.

- You get help paying for your drugs from other organizations, like a State Pharmaceutical Assistance Program (SPAP) or other health coverage.
- Your yearly drug costs are low.
- Your drug costs are the same each month.
- You're considering signing up for the payment option late in the calendar year (after September).
- You don't want to change how you pay for your drugs.

Who can help me decide if I should sign up for this payment option?

- **Your plan:** Visit your plan's website, or call your plan to get more information. Your plan's phone number is on the back of your membership card.
- **Medicare:** Visit Medicare.gov/tbd, or call 1-800-MEDICARE (1-800- 633-4227), 24 hours a day, 7 days a week. TTY users can call 1-877-486-2048.
- **State Health Insurance Program (SHIP):** Visit shiphelp.org to get the phone number for your local SHIP and get free, personalized health insurance counseling.

How do I sign up for this payment option?

To sign up for this payment option, visit your plan's website or call your plan. You can find your plan's phone number on the back of your membership card. If you need to pick up a prescription urgently, the fastest way to use this payment option is to call your plan.

Need this information in another format or language?

To get this material in other formats like large print, braille, or another language, contact your Medicare drug plan. If you need help contacting your plan, call: 1-800-MEDICARE (1-800-633-4227).

Exhibit 2 – Part D Sponsor Initial Notice for Failure to Make Payments under the Medicare Prescription Payment Plan

Referenced in [insert draft part 2 guidance section]

Part D sponsors may insert a title for the notice, such as "Urgent: Pay your Medicare Prescription Payment Plan bill">

<Member #>

<RxID>

<RxGroup>

<RxBin>

<RxPCN>

Dear < Member>:

We didn't get your monthly payment for the Medicare Prescription Payment Plan that was due <insert payment due date>. To stay in the Medicare Prescription Payment Plan, you must pay <insert the full amount or a partial amount(s) should the plan choose to allow enrollees to pay the balance over separate payments> by <insert date for the end of the grace period (i.e., the date that is two calendar months from the first day of the month for which the balance is unpaid or the first day of the month following the date on which the payment is requested, whichever is later)>.

This letter only applies to your participation in the Medicare Prescription Payment Plan. Your Medicare drug coverage and other Medicare benefits won't be affected, and you'll continue to be enrolled in <plan name> for your drug coverage.

How do I pay my bill?

You can choose to pay the amount you owe all at once or be billed monthly. You'll never pay any interest or fees on the amount you owe.

You owe <insert unpaid>. You can pay:

- Online at <plan's website>, by credit/debit card.
- Through the mail, by check.
- <insert other payment methods offered by the plan like electronic funds transfer (including automatic charges of an account at a financial institution or credit or debit card account)>.

If you have questions about your payment, call us at <phone number>, <days and hours of operation>. TTY users can call < TTY number>.

What happens if I don't pay my bill?

If you don't pay your bill by <insert effective date>, you'll no longer be in the Medicare Prescription Payment Plan through <plan sponsor>. As of <effective date>, you'll pay the pharmacy directly for your out-of-pocket drug costs.

Like any other debt, you're required to pay the amount you owe. As long as you continue to pay your plan premium (if you have one), you'll still have drug coverage through <plan name>.

What if I think there's been a mistake?

If you think that we've made a mistake, call us at <phone number>. You also have the right to ask us to reconsider our decision through a grievance process. Check your <insert "Member Handbook" or "Evidence of Coverage," as appropriate>.

What if I can't afford to pay both my plan premium and my Medicare Prescription Payment Plan payment?

Always pay your <plan name> premium first (if you have one). If needed, we can apply a payment you've made toward your **Medicare Prescription Payment Plan** balance to your plan premium instead. Call us at <phone number> to discuss this option.

Are there programs that can help lower my costs?

While the Medicare Prescription Payment Plan spreads out your costs, it doesn't lower them. However, you may be eligible for programs that can help lower your costs, like:

- **Extra Help:** A Medicare program that helps pay your Medicare drug costs if you have limited income and resources. Visit secure.ssa.gov/i1020/start to find out if you qualify and apply. You can also apply with your state's Medicaid office. Visit Medicare.gov/basics/costs/help/drug-costs to learn more.
- **Medicare Savings Program**: A state-run program that helps people with limited income and resources pay some or all of their Medicare premiums, deductibles, and coinsurance. Visit Medicare.gov/medicare-savings-programs to learn more.
- **State Pharmaceutical Assistance Program (SPAP):** A program that may include coverage for your Medicare drug plan premiums and/or cost sharing. SPAP contributions may count toward your Medicare drug coverage out-of-pocket limit. Visit go.medicare.gov/spap to learn more.
- **Manufacturer's Pharmaceutical Assistance Programs** (sometimes called Patient Assistance Programs (PAPs)): A program from drug manufacturers to help lower drugs costs for people with Medicare. Visit go.medicare.gov/pap to learn more.

Many people qualify for savings and don't realize it. Visit Medicare.gov/basics/costs/help, or contact your local Social Security office to learn more. Find your local Social Security office at secure.ssa.gov/ICON/main.jsp or call 1-800-772-1213. TTY users can call 1-800-325-0778.

Note: The programs listed above can help lower your costs, but they can't help you pay off your Medicare Prescription Payment Plan balance.

UNITEDHEALTH GROUP

9900 Bren Road East, MN000-T000,
Minnetonka, MN 55343

April 29, 2024

Center for Medicare & Medicaid Services
Office of Strategic Operations and Regulatory Affairs
Division of Regulations Development
Attention: CMS–10882
Room C4–26–05
7500 Security Boulevard
Baltimore, MD 21244–1850

Submitted Electronically: www.regulations.gov

Re: The Medicare Advantage and Prescription Drug Programs: Part C and Part D Medicare Prescription Payment Plan Model Documents (CMS-10882)

Dear Sir/Madam:

UnitedHealth Group (UHG) is pleased to respond to the Centers for Medicare and Medicaid Services' (CMS) request for comments regarding the *Medicare Advantage and Prescription Drug Programs: Part C and Part D Medicare Prescription Payment Plan Model Documents.*

UnitedHealth Group is a mission-driven organization dedicated to helping people live healthier lives and helping make the health system work better for everyone through two distinct platforms - UnitedHealthcare, our health benefits business, and Optum, our health services business. We work with employers, providers, and governments to serve people and share a vision of a value-based system of care that provides compassionate and equitable care. We are committed to a future where every person has access to high-quality, affordable health care and a modern, high-performing health system that reduces disparities, improves outcomes, and lessens the burden of disease.

UHG has organized its comments by model notice document and has included additional suggestions for clarity and readability in the attached documents, along with track changes.

Consider Managing Your Monthly Drug Costs with the Medicare Prescription Payment Plan

- Given the timing of when individuals may enroll into the program, references to the specific months of the year may lead to confusion, if for example, the Notice is provided mid-year. UHG recommends CMS consider revising as follows:
    - Proposed: *monthly payments that vary throughout the year (January – December)*
    - Revised: *monthly payments that vary throughout the remaining months of the plan year.*
- Although the description of the plan types under the section *What's the Medicare Prescription Payment Plan?* is similar to the language used in the Medicare

Prescription Payment Plan draft guidance, it could create enrollee confusion. UHG recommends CMS consider revising as follows:
    - Proposed: Medicare drug plans and Medicare health plans with drug coverage (like a Medicare Advantage Plan)
    - Revised: Medicare plans with Part D prescription drug coverage.
- Under the section *Will this payment option help me?*, UHG recommends CMS consider adding examples or a link to a website or a QR link for beneficiaries to review examples to help them determine if the payment option is right for their situation.

Exhibit 1 – *Part D Sponsor Notice to Acknowledge Acceptance of Election in the Medicare Prescription Payment Plan*

- UHG recommends CMS consider making the Rx ID, Rx Group, Rx Bin, and Rx PCN optional fields that can be populated at the top of the document because that information will likely not be meaningful to the beneficiary, may lead to confusion, and/or will be administratively burdensome to add to the letter.
- Under the section *How is my monthly bill calculated?*, UHG recommends CMS consider modifying the language to account for situations where a beneficiary does not have a balance from the previous month. In UHG's initial testing, beneficiaries found the proposed language to be confusing.
    - Proposed: *Your monthly bill is based on what you owe for any prescriptions you get, plus your previous month's balance, divided by the number of months left in the year.*
    - Revised: *Your monthly bill is based on what you owe for any prescriptions you get, plus any prior month's balance, if applicable, divided by the number of months left in the year.*
- In addition, UHG recommends CMS consider revising references to "calendar year" and/or to specific months of the year when it may lead to beneficiary confusion. For example, if the enrollee is in a non-calendar year employer group waiver plan (EGWP) or if the beneficiary does not enroll in the program in January. UHG recommends CMS consider revising the following:
    - Proposed: *Remember, in a single calendar year (Jan – Dec), you'll never pay more than:*
    - Revised: *Remember, in a single plan year, you'll never pay more than:*
- Under the section *Can I leave the Medicare Prescription Payment Plan?*, UHG recommends CMS bracket this language to give Part D sponsors the ability to provide other options for enrollees to opt-out, in addition to the phone number.[1]

Exhibit 2 – *Part D Sponsor Initial Notice for Failure to Make Payments under the Medicare Prescription Payment Plan*

- UHG recommends CMS consider making the Rx ID, Rx Group, Rx Bin, and Rx PCN optional fields that can be populated at the top of the document because that information will likely not be meaningful to the beneficiary, may lead to confusion, and/or will be administratively burdensome to add to the letter.

[1] As proposed, the draft Part Two guidance does not limit voluntary termination to only phone calls.

- In the section titled, *What if I can't afford to pay both my plan premium and my Medicare Prescription Payment Plan payment?*, it states that if needed, Part D sponsors can apply a payment toward a beneficiary's Medicare Prescription Payment Plan balance to their Part D plan premium instead. UHG is concerned that offering to move payments between the Medicare Prescription Payment Plan and plan premiums will introduce further complexities into the program, particularly if the Part D sponsor has delegated the administration of the Medicare Prescription Payment Plan to their Pharmacy Benefit Manager or another external vendor. Since this type of payment option is not a requirement set forth in the draft Part Two guidance, UHG strongly encourages CMS remove this option from the Exhibit.

Exhibit 3 - ***Part D Sponsor Notice for Failure to Make Payments under Medicare Prescription Payment Plan - Notification of Termination of Participation in the Medicare Prescription Payment Plan***

- UHG recommends CMS consider making the Rx ID, Rx Group, Rx Bin, and Rx PCN optional fields that can be populated at the top of the document because that information will likely not be meaningful to the beneficiary, may lead to confusion, and/or will be administratively burdensome to add to the letter.
- In the section titled, *Can I use this payment option in the future?*, UHG recommends CMS consider revising the title to incorporate the program or payment plan language instead of using the words "payment option" to avoid any potential enrollee confusion.
    - Proposed: *Can I use this payment option in the future?*
    - Revised: *Can I rejoin this program/the Medicare Prescription Payment Plan in the future?*

Exhibit 4 - Part D Sponsor Notification of Voluntary Removal from the Medicare Prescription Payment Plan

- UHG recommends CMS consider making the Rx ID, Rx Group, Rx Bin, and Rx PCN optional fields that can be populated at the top of the document because that information will likely not be meaningful to the beneficiary, may lead to confusion, and/or will be administratively burdensome to add to the letter.
- UHG recommends CMS consider making the second and third paragraphs of this notice variable to allow Part D sponsors to tailor the language to the specific reason for why the enrollee is discontinuing participation in the program. Attempting to address more than one scenario (i.e., where an enrollee is staying in their current Part D plan versus leaving their current Part D plan) in the same required text, may lead to beneficiary confusion.
    - Proposed: *You're getting this letter because you either asked to stop participating in this payment option, or you changed your Medicare drug plan or Medicare health plan with drug coverage (like a Medicare Advantage Plan). If you changed plans, and you'd like to join the Medicare Prescription Payment Plan offered through your new plan, contact your new plan. This letter only applies to your participation in the Medicare Prescription Payment Plan. Your Medicare drug coverage and other Medicare benefits won't be affected, and you'll continue to be enrolled in <plan name> for your drug coverage.*

- Revised Option 1 (disenroll from program only): *You're getting this letter because you asked to stop participating in the Medicare Prescription Payment Plan. This letter only applies to your participation in the Medicare Prescription Payment Plan. Your Medicare drug coverage and other Medicare benefits won't be affected, and you'll continue to be enrolled in <plan name> for your drug coverage.*
- Revised Option 2 (disenroll from program and Part D plan): *You're getting this letter because you disenrolled from <plan name>. When you disenroll from your plan, your participation in the Medicare Prescription Payment Plan automatically ends. If you changed plans, and you'd like to join the Medicare Prescription Payment Plan offered through your new plan, contact your new plan.*

We appreciate CMS's consideration of our comments. Please feel free to contact me if you have any questions.

Sincerely,

Jennifer Martin
Director, Regulatory Affairs
UnitedHealthcare
jennifer_j_martin@uhc.com
763-283-4469

~~Consider~~ Managing Your Monthly Drug Costs with the Medicare Prescription Payment Plan

You might benefit from participating in the Medicare Prescription Payment Plan, because you have high drug costs. This ~~new payment option~~program ~~works with your current drug coverage, and it can~~ helps participants ~~you~~ manage ~~your~~ their drug costs by spreading them across **monthly payments that vary throughout the remaining months of the plan year** ~~(January – December).~~

What's the Medicare Prescription Payment Plan?

The Medicare Prescription Payment Plan is a new payment option to help you manage your out-of-pocket drug costs, starting in 2025. All Medicare ~~drug~~ plans ~~and Medicare health plans~~ with Part D prescription drug coverage ~~(like a Medicare Advantage Plan)~~ must offer this payment option, and all plans use the same formula to calculate your monthly payments. If you select this payment option, each month you'll pay your plan premium (if you have one) and you'll get a separate bill from your ~~health or drug~~ plan for your prescription drugs (instead of paying the pharmacy).

Participating in this payment option is voluntary. Anyone with a Medicare ~~drug plan or a Medicare health plan with drug coverage~~ Part D prescription drug plan can use this payment option for covered drugs.~~, which applies to all prescription drugs covered by Part D~~. It doesn't cost anything to participate in the Medicare Prescription Payment Plan, and you won't pay any interest or fees on the amount you owe, even if your payment is late.

Will this payment option help me?

It depends on your situation. If you have high out-of-pocket drug costs, this payment option spreads out what you'll pay each month across the plan year ~~(January – December),~~ so you don't have to pay out-of-pocket costs to the pharmacy. **This payment option might help you manage your expenses, but it doesn't save you money or lower your drug costs.** Visit Medicare.gov/basics/costs/help/drug-costs to learn about programs that can help lower your drug costs.

How will my costs work with this payment option?

The new prescription drug law caps your out-of-pocket costs at $2,000 in 2025 and eliminates the coverage gap (known as the "donut hole"). This means you'll never pay more than $2,000 in out-of-pocket drug costs in 2025. **This is true for everyone with Medicare drug coverage, even if you don't join the Medicare Prescription Payment Plan.**

When you fill a prescription for a ~~drug~~ covered by Part D drug, you won't pay your pharmacy (including mail-order and specialty pharmacies). Instead, you'll get a bill each month from your plan. Your monthly bill is based on what you owe for any prescriptions you get, plus your previous month's balance, divided by the number of months left in the year.

Note: Your payments might change every month, so you might not know what your exact bill will be ahead of time. Future payments might increase when you fill a new prescription or refill an existing prescription because as new out-of-pocket drug costs are added into your monthly payment, there are fewer months left in the year to spread out your payments.

You're required to pay the amount you owe for your medications. If you don't pay your bill, you'll be removed from the Medicare Prescription Payment Plan.

<placeholder for cost example>

Commented [BLM(RA1]: We recommend this edit for simplification.

Commented [BLM(RA2]: We recommend simplifying and removing reference to January - December since not all members will opt-in in January, and some EGWP plans will not operate on a January - December calendar year.

Commented [BLM(RA3]: We recommend these edits for clarity and simplification.

Commented [BLM(RA4]: We recommend these edits for simplification.

Commented [BLM(RA5]: We recommend referring to the plan year since not all members will opt-in during January, and some EGWP plans operation on a non-calendar-year schedule.

Commented [BLM(RA6]: We suggest moving this paragraph up to the second paragraph below the letter title to highlight changes to the coverage gap and OOP costs that apply to all members.

Commented [BLM(RA7]: We request that CMS permit plans to insert a graphic and/or text example to help illustrate how costs work with the program.

~~**How do I know if this payment option might not be right for me?**~~

This payment option might not be helpful for you if:

- You get Extra Help from Medicare.
- You qualify for a Medicare Savings Program.
- You get help paying for your drugs from other organizations, like a State Pharmaceutical Assistance Program (SPAP) or other health coverage.
- Your yearly drug costs are low.
- Your drug costs are the same each month.
- You're considering signing up for the payment option late in the plan ~~calendar~~ year ~~(after September)~~.
- You don't want to change how you pay for your drugs.

Who can help me decide if I should sign up for this payment option?

- **Your plan:** Visit your plan's website, or call your plan to get more information. Your plan's phone number is on the back of your ~~membership~~ ID card.
- **Medicare:** Visit Medicare.gov/tbd, or call 1-800-MEDICARE (1-800- 633-4227), 24 hours a day, 7 days a week. TTY users can call 1-877-486-2048.
- **State Health Insurance Program (SHIP):** Visit shiphelp.org to get the phone number for your local SHIP and get free, personalized health insurance counseling.

How do I sign up for this payment option?

To sign up for this payment option, visit your plan's website or call your plan. You can find your plan's phone number on the back of your ~~membership~~ ID card. If you need to pick up a prescription urgently, the fastest way to use this payment option is to call your plan.

Need this information in another format or language?

To get this material in other formats like large print, braille, or another language, contact your ~~Medicare drug~~ plan. If you need help contacting your plan, call: 1-800-MEDICARE (1-800-633-4227).

Commented [BLM(RA8]: We recommend removing this language based on feedback received during member testing - members expressed confusion with the language.

Commented [BLM(RA9]: We recommend removing this header and moving the sub-header and content to the "the will this payment option help me" section. This will give the member all of the information in one spot to determine if the program will benefit them or not.

Commented [BLM(RA10]: We recommend this edit to align with how ID cards are referenced in other materials.

Commented [BLM(RA11]: We recommend this edit to align with how ID cards are referenced in other materials.

Commented [BLM(RA12]: We recommend adjusting this language avoid any potential member confusion between Medicare and Plan.

Managing Your Monthly Drug Costs with the Medicare Prescription Payment Plan

You might benefit from participating in the Medicare Prescription Payment Plan, because you have high drug costs. This program helps participants manage their drug costs by spreading them across **monthly payments that vary throughout the remaining months of the plan year**.

What's the Medicare Prescription Payment Plan?

The Medicare Prescription Payment Plan is a new payment option to help you manage your out-of-pocket drug costs, starting in 2025. All Medicare plans with Part D prescription drug coverage must offer this payment option, and all plans use the same formula to calculate your monthly payments. If you select this payment option, each month you'll pay your plan premium (if you have one) and you'll get a separate bill from your plan for your prescription drugs (instead of paying the pharmacy).

Participating in this payment option is voluntary. Anyone with a Medicare Part D prescription drug plan can use this payment option for covered drugs. It doesn't cost anything to participate in the Medicare Prescription Payment Plan, and you won't pay any interest or fees on the amount you owe, even if your payment is late.

Will this payment option help me?

It depends on your situation. If you have high out-of-pocket drug costs, this payment option spreads out what you'll pay each month across the plan year so you don't have to pay out-of-pocket costs to the pharmacy. **This payment option might help you manage your expenses, but it doesn't save you money or lower your drug costs.** Visit Medicare.gov/basics/costs/help/drug-costs to learn about programs that can help lower your drug costs.

How will my costs work with this payment option?

The new prescription drug law caps your out-of-pocket costs at $2,000 in 2025 and eliminates the coverage gap (known as the "donut hole"). This means you'll never pay more than $2,000 in out-of-pocket drug costs in 2025. **This is true for everyone with Medicare drug coverage, even if you don't join the Medicare Prescription Payment Plan.**

When you fill a prescription for a covered by Part D drug, you won't pay your pharmacy (including mail-order and specialty pharmacies). Instead, you'll get a bill each month from your plan. Your monthly bill is based on what you owe for any prescriptions you get, plus your previous month's balance, divided by the number of months left in the year.

Note: Your payments might change every month, so you might not know what your exact bill will be ahead of time. Future payments might increase when you fill a new prescription or refill an existing prescription because as new out-of-pocket drug costs are added into your monthly payment, there are fewer months left in the year to spread out your payments.

You're required to pay the amount you owe for your medications. If you don't pay your bill, you'll be removed from the Medicare Prescription Payment Plan.

<placeholder for cost example>

This payment option might not be helpful for you if:

- You get Extra Help from Medicare.
- You qualify for a Medicare Savings Program.

- You get help paying for your drugs from other organizations, like a State Pharmaceutical Assistance Program (SPAP) or other health coverage.
- Your yearly drug costs are low.
- Your drug costs are the same each month.
- You're considering signing up for the payment option late in the plan year.
- You don't want to change how you pay for your drugs.

Who can help me decide if I should sign up for this payment option?

- **Your plan:** Visit your plan's website, or call your plan to get more information. Your plan's phone number is on the back of your ID card.
- **Medicare:** Visit Medicare.gov/tbd, or call 1-800-MEDICARE (1-800- 633-4227), 24 hours a day, 7 days a week. TTY users can call 1-877-486-2048.
- **State Health Insurance Program (SHIP):** Visit shiphelp.org to get the phone number for your local SHIP and get free, personalized health insurance counseling.

How do I sign up for this payment option?

To sign up for this payment option, visit your plan's website or call your plan. You can find your plan's phone number on the back of your ID card. If you need to pick up a prescription urgently, the fastest way to use this payment option is to call your plan.

Need this information in another format or language?

To get this material in other formats like large print, braille, or another language, contact your plan. If you need help contacting your plan, call: 1-800-MEDICARE (1-800-633-4227).

Exhibit 1 – Part D Sponsor Notice to Acknowledge Acceptance of Election in the Medicare Prescription Payment Plan

Referenced in [insert draft part 2 guidance section]

<Part D sponsors may insert a title for the notice, such as "You're now participating in the Medicare Prescription Payment Plan">

<Member #>

<RxID>

<RxGroup>

<RxBin>

<RxPCN>

<Date>

Dear <Name of Member>,

Welcome to the Medicare Prescription Payment Plan, a payment option that works with your <plan name>. Your participation starts on <insert date>.

What happens now?

1. We'll let your pharmacy (including mail-order and specialty pharmacies) know that you're using this payment option.
2. When you fill a prescription for a drug covered by Part D, you won't pay your pharmacy for the prescription.
3. Each month <plan name> will send you a bill with the amount you owe, when it's due, and information on how to make a payment. You'll get a separate bill for your monthly plan premium (if you have one).

How is my monthly bill calculated?

Your monthly bill is based on what you owe for any prescriptions you get, plus ~~your~~ any previous month's balance, divided by the number of months left in the year.

Your payments might change every month, so you might not know what your exact bill will be ahead of time. Future payments might increase when you fill a new prescription or refill an existing prescription because as new out-of-pocket costs are added into your monthly payment, there are fewer months left in the year to spread out your payments. You'll never pay any interest or fees on the amount you owe, even if your payment is late.

Remember, in a single ~~calendar year (Jan – Dec)~~plan year, you'll never pay more than:

- The total amount you would have paid out of pocket to the pharmacy.
- The Medicare drug coverage annual out-of-pocket maximum (which is $2,000 in 2025).

What happens if I don't pay my bill?

We'll send you a reminder if you miss a payment. If you don't pay your bill by the date listed in that reminder, you'll be removed from the Medicare Prescription Payment Plan. Like any other debt, you're

Commented [BLM(RA1]: We recommend making these Rx fields optional for plans, due to potential operational challenges.

Commented [BLM(RA2]: We recommend saying plan year since not all member will enroll in January, and EGWP members may have non-calendar-year plans.

required to pay the amount you owe for your medications. Always pay your <plan name> premium first (if you have one), so you don't lose your drug coverage.

If you think that we've made a mistake with the amount you owe, call us at <phone number>. You also have the right to follow the grievance process found in your <insert "Member Handbook" or "Evidence of Coverage," as appropriate>.

Can I leave the Medicare Prescription Payment Plan?

You can leave the Medicare Prescription Payment Plan at any time by <calling us at <phone number>>. If you still owe a balance, you're required to pay the amount you owe, even though you're no longer participating in the program. You can choose to pay the remaining amount all at once or be billed monthly. If you leave, your Medicare drug coverage and other Medicare benefits won't be affected, and you'll go back to paying the pharmacy directly for all your out-of-pocket drug costs.

If you leave <current plan name> or change to a new Medicare drug plan or Medicare health plan with drug coverage (like a Medicare Advantage Plan) your participation in the Medicare Prescription Payment Plan will end. If you change plans, and you'd like to join the Medicare Prescription Payment Plan offered through your new plan, contact your new plan.

Are there programs that can help lower my costs?

While the Medicare Prescription Payment Plan spreads out your costs, it doesn't lower them. However, you may be eligible for programs that can help lower your costs, like:

- **Extra Help:** A Medicare program that helps pay your Medicare drug costs if you have limited income and resources. Visit secure.ssa.gov/i1020/start to find out if you qualify and apply. You can also apply with your state's Medicaid office. Visit Medicare.gov/basics/costs/help/drug-costs to learn more.
- **Medicare Savings Program**: A state-run program that helps people with limited income and resources pay some or all of their Medicare premiums, deductibles, and coinsurance. Visit Medicare.gov/medicare-savings-programs to learn more.
- **State Pharmaceutical Assistance Program (SPAP):** A program that may include coverage for your Medicare drug plan premiums and/or cost sharing. SPAP contributions may count toward your Medicare drug coverage out-of-pocket limit. Visit go.medicare.gov/spap to learn more.
- **Manufacturer's Pharmaceutical Assistance Programs** (sometimes called Patient Assistance Programs (PAPs)): A program from drug manufacturers to help lower drugs costs for people with Medicare. Visit go.medicare.gov/pap to learn more.

Many people qualify for savings and don't realize it. Visit Medicare.gov/basics/costs/help, or contact your local Social Security office to learn more. Find your local Social Security office at secure.ssa.gov/ICON/main.jsp or call 1-800-772-1213. TTY users can call 1-800-325-0778.

Commented [BLM(RA3]: We recommend this edit for clarity.

Commented [BLM(RA4]: We recommend bracketing this language to give plans other options for participants to opt-out of MPPP (i.e., online)

Exhibit 2 – Part D Sponsor Initial Notice for Failure to Make Payments under the Medicare Prescription Payment Plan

Referenced in [insert draft part 2 guidance section]

<Part D sponsors may insert a title for the notice, such as "Urgent: Pay your Medicare Prescription Payment Plan bill">

<Member #>

<RxID>

<RxGroup>

<RxBin>

<RxPCN>

Commented [BLM(RA1]: We recommend making these Rx fields optional for plans, due to potential operational challenges.

Dear < Member>:

We didn't get your monthly payment for the Medicare Prescription Payment Plan that was due <insert payment due date>. To stay in the Medicare Prescription Payment Plan, you must pay <insert the full amount or a partial amount(s) should the plan choose to allow enrollees to pay the balance over separate payments> by <insert date for the end of the grace period (i.e., the date that is two calendar months from the first day of the month for which the balance is unpaid or the first day of the month following the date on which the payment is requested, whichever is later)>.

This letter only applies to your participation in the Medicare Prescription Payment Plan. Your Medicare drug coverage and other Medicare benefits won't be affected, and you'll continue to be enrolled in <plan name> for your drug coverage.

How do I pay my bill?

You can choose to pay the amount you owe all at once or be billed monthly. You'll never pay any interest or fees on the amount you owe.

You owe <insert unpaid>. You can pay:

- Online at <plan's website>, by credit/debit card.
- Through the mail, by check.
- <insert other payment methods offered by the plan like electronic funds transfer (including automatic charges of an account at a financial institution or credit or debit card account)>.

If you have questions about your payment, call us at <phone number>, <days and hours of operation>. TTY users can call < TTY number>.

What happens if I don't pay my bill?

If you don't pay your bill by <insert effective date>, you'll no longer be in the Medicare Prescription Payment Plan through <plan sponsor>. As of <effective date>, you'll pay the pharmacy directly for your out-of-pocket drug costs.

Like any other debt, you're required to pay the amount you owe for your medications. As long as you continue to pay your plan premium (if you have one), you'll still have drug coverage through <plan name>.

Commented [BLM(RA2]: We recommend this edit for clarity.

What if I think there's been a mistake?

If you think that we've made a mistake, call us at <phone number>. You also have the right to ask us to reconsider our decision through a grievance process. Check your <insert "Member Handbook" or "Evidence of Coverage," as appropriate>.

What if I can't afford to pay both my plan premium and my Medicare Prescription Payment Plan payment?

Always pay your <plan name> premium first (if you have one). If needed, we can apply a payment you've made toward your **Medicare Prescription Payment Plan** balance to your plan premium instead. Call us at <phone number> to discuss this option.

Are there programs that can help lower my costs?

While the Medicare Prescription Payment Plan spreads out your costs, it doesn't lower them. However, you may be eligible for programs that can help lower your costs, like:

- **Extra Help:** A Medicare program that helps pay your Medicare drug costs if you have limited income and resources. Visit secure.ssa.gov/i1020/start to find out if you qualify and apply. You can also apply with your state's Medicaid office. Visit Medicare.gov/basics/costs/help/drug-costs to learn more.
- **Medicare Savings Program**: A state-run program that helps people with limited income and resources pay some or all of their Medicare premiums, deductibles, and coinsurance. Visit Medicare.gov/medicare-savings-programs to learn more.
- **State Pharmaceutical Assistance Program (SPAP):** A program that may include coverage for your Medicare drug plan premiums and/or cost sharing. SPAP contributions may count toward your Medicare drug coverage out-of-pocket limit. Visit go.medicare.gov/spap to learn more.
- **Manufacturer's Pharmaceutical Assistance Programs** (sometimes called Patient Assistance Programs (PAPs)): A program from drug manufacturers to help lower drugs costs for people with Medicare. Visit go.medicare.gov/pap to learn more.

Many people qualify for savings and don't realize it. Visit Medicare.gov/basics/costs/help, or contact your local Social Security office to learn more. Find your local Social Security office at secure.ssa.gov/ICON/main.jsp or call 1-800-772-1213. TTY users can call 1-800-325-0778.

Note: The programs listed above can help lower your costs, but they can't help you pay off your Medicare Prescription Payment Plan balance.

Exhibit 3 - Part D Sponsor Notice for Failure to Make Payments under Medicare Prescription Payment Plan - Notification of Termination of Participation in the Medicare Prescription Payment Plan

Referenced in [insert draft part 2 guidance section]

<Part D sponsors may insert a title for the notice, such as "Important: Your participation in the Medicare Prescription Payment Plan has ended">

<Member #>

<RxID>

<RxGroup>

<RxBin>

<RxPCN>

Commented [BLM(RA1]: We recommend making these Rx fields optional for plans, due to potential operational challenges.

<Date>

Dear < Member>,

On <date of initial notification of failure to pay>, we sent you a letter letting you know your monthly payment for the Medicare Prescription Payment Plan was overdue. The letter explained that if you didn't make your payment by <insert time frame>, we'd end your participation in the Medicare Prescription Payment Plan.

Starting <insert effective date, which should be the same date as this letter>, you're no longer participating in the Medicare Prescription Payment Plan through <plan sponsor> because we didn't get your monthly payment. Like any other debt, you're still required to pay the amount you owe for your medications, $<amount owed>.

Commented [BLM(RA2]: We recommend this edit for clarity.

As of <effective date>, you'll pay the pharmacy directly for all your out-of-pocket drug costs.

This letter only applies to your participation in the Medicare Prescription Payment Plan. Your Medicare drug coverage and other Medicare benefits won't be affected, and you'll continue to be enrolled in <plan name> for your drug coverage.

How do I pay my balance?

You can choose to pay the amount you owe all at once or be billed monthly. You'll never pay any interest or fees on the amount you owe.

You owe <insert unpaid>. You can pay:

- Online at <plan's website>, by credit or debit card.
- Through the mail, by check.
- <insert other payment methods offered by the plan sponsor like electronic funds transfer (including automatic charges of an account at a financial institution or credit or debit card account)>.

If you have questions about your payment, call us at <phone number>, <days and hours of operation>. TTY users can call <TTY number>.

What if I think there's been a mistake?

If you think that we've made a mistake, call us at <phone number>. You also have the right to ask us to reconsider our decision through the grievance process in your <insert "Member Handbook" or "Evidence of Coverage," as appropriate>.

Can I use this payment option in the future?

Yes, once you pay the total amount you owe.

Are there programs that can help lower my costs?

You may be eligible for programs that can help lower your costs, like:

- **Extra Help:** A Medicare program that helps pay your Medicare drug costs if you have limited income and resources. Visit secure.ssa.gov/i1020/start to find out if you qualify and apply. You can also apply with your state's Medicaid office. Visit Medicare.gov/basics/costs/help/drug-costs to learn more.
- **Medicare Savings Program**: A state-run program that helps people with limited income and resources pay some or all of their Medicare premiums, deductibles, and coinsurance. Visit Medicare.gov/medicare-savings-programs to learn more.
- **State Pharmaceutical Assistance Program (SPAP):** A program that may include coverage for your Medicare drug plan premiums and/or cost sharing. SPAP contributions may count toward your Medicare drug coverage out-of-pocket limit. Visit go.medicare.gov/spap to learn more.
- **Manufacturer's Pharmaceutical Assistance Programs** (sometimes called Patient Assistance Programs (PAPs)): A program from drug manufacturers to help lower drugs costs for people with Medicare. Visit go.medicare.gov/pap to learn more.

Many people qualify for savings and don't realize it. Visit Medicare.gov/basics/costs/help, or contact your local Social Security office to learn more. Find your local Social Security office at secure.ssa.gov/ICON/main.jsp or call 1-800-772-1213. TTY users can call 1-800-325-0778.

Note: The programs listed above can help lower your costs, but they can't help you pay off your Medicare Prescription Payment Plan balance.

Exhibit 4 - Part D Sponsor Notification of Voluntary Removal from the Medicare Prescription Payment Plan

Referenced in [insert draft part 2 guidance section]

<Part D sponsors may insert a title for the notice, such as "You're no longer participating in the Medicare Prescription Payment Plan through <plan sponsor>">

<Member #>

<RxID>

<RxGroup>

<RxBin>

<RxPCN>

Commented [BLM(RA1]: We recommend making these Rx fields optional for plans, due to potential operational challenges.

Dear <Member>,

Starting <insert effective date>, you're no longer participating in the Medicare Prescription Payment Plan through <plan sponsor>. As of <effective date>, you'll pay the pharmacy directly for your out-of-pocket drug costs.

You're getting this letter because you either asked to stop participating in this payment option, **or** you changed your Medicare drug plan or Medicare health plan with drug coverage (like a Medicare Advantage Plan). If you changed plans, and you'd like to join the Medicare Prescription Payment Plan offered through your new plan, contact your new plan.

This letter only applies to your participation in the Medicare Prescription Payment Plan. Your Medicare drug coverage and other Medicare benefits won't be affected, and you'll continue to be enrolled in <plan name> for your drug coverage.

Commented [BLM(RA2]: We recommend making both of these paragraphs variable so the letter may more accurately reflect the member scenario. See below variable inclusions for further context.

[If disenrolling from Medicare Prescription Payment Plan only: You're getting this letter because you asked to stop participating in the Medicare Prescription Payment Plan.

This letter only applies to your participation in the Medicare Prescription Payment Plan. You'll continue to get your [MAPD: medical and] and prescription drug coverage through <plan name>.]

[If disenrolling from plan and Medicare Prescription Payment Plan: You're getting this letter because you disenrolled from <plan name>. When you disenroll from your plan, your participation in the Medicare Prescription Payment Plan automatically ends.]

How do I pay my balance?

If you have an outstanding balance ~~Y~~you can choose to pay the amount you owe all at once or be billed monthly. You'll never pay any interest or fees on the amount you owe, even if your payment is late.

Commented [BLM(RA3]: We recommend adjusting since not all beneficiaries will have an outstanding balance.

You owe <insert unpaid>. You can pay:

- Online at <plan's website>, by credit or debit card.
- Through the mail, by check.
- <insert other payment methods offered by the plan sponsor like electronic funds transfer (including automatic charges of an account at a financial institution or credit or debit card account)>.

If you have questions about your payment, call us at <phone number>, <days and hours of operation>. TTY users can call <TTY number>.

What happens if I don't pay my balance?

Like any other debt, you're required to pay the amount you owe for you medications. As long as you continue to pay your plan premium (if you have one), you'll still have drug coverage.

Commented [BLM(RA4]: We recommend this edit for clarity.

Can I use this payment option in the future?

- **If you're still in <plan name>:** Yes. Visit <insert PDP webpage where the application is>, or call us at <phone number> <days and hours of operation>. TTY users can call <TTY number>.
- **If you're joining a new plan:** Yes. All Medicare drug plans and Medicare health plans with drug coverage must offer this payment option. No matter what Medicare drug plan you're in, you can choose to rejoin the Medicare Prescription Payment Plan at any time.

Are there programs that can help lower my costs?

You may be eligible for programs that can help lower your costs, like:

- **Extra Help:** A Medicare program that helps pay your Medicare drug costs if you have limited income and resources. Visit secure.ssa.gov/i1020/start to find out if you qualify and apply. You can also apply with your state's Medicaid office. Visit Medicare.gov/basics/costs/help/drug-costs to learn more.
- **Medicare Savings Program**: A state-run program that helps people with limited income and resources pay some or all of their Medicare premiums, deductibles, and coinsurance. Visit Medicare.gov/medicare-savings-programs to learn more.
- **State Pharmaceutical Assistance Program (SPAP):** A program that may include coverage for your Medicare drug plan premiums and/or cost sharing. SPAP contributions may count toward your Medicare drug coverage out-of-pocket limit. Visit go.medicare.gov/spap to learn more.
- **Manufacturer's Pharmaceutical Assistance Programs** (sometimes called Patient Assistance Programs (PAPs)): A program from drug manufacturers to help lower drugs costs for people with Medicare. Visit go.medicare.gov/pap to learn more.

Many people qualify for savings and don't realize it. Visit Medicare.gov/basics/costs/help, or contact your local Social Security office to learn more. Find your local Social Security office at secure.ssa.gov/ICON/main.jsp or call 1-800-772-1213. TTY users can call 1-800-325-0778.

Note: The programs listed above can help lower your costs, but they can't help you pay off your Medicare Prescription Payment Plan balance.

Exhibit 1 – Part D Sponsor Notice to Acknowledge Acceptance of Election in the Medicare Prescription Payment Plan

Referenced in [insert draft part 2 guidance section]

<Part D sponsors may insert a title for the notice, such as "You're now participating in the Medicare Prescription Payment Plan">

<Member #>

<RxID>

<RxGroup>

<RxBin>

<RxPCN>

<Date>

Dear <Name of Member>,

Welcome to the Medicare Prescription Payment Plan, a payment option that works with your <plan name>. Your participation starts on <insert date>.

What happens now?

1. We'll let your pharmacy (including mail-order and specialty pharmacies) know that you're using this payment option.
2. When you fill a prescription for a drug covered by Part D, you won't pay your pharmacy for the prescription.
3. Each month <plan name> will send you a bill with the amount you owe, when it's due, and information on how to make a payment. You'll get a separate bill for your monthly plan premium (if you have one).

How is my monthly bill calculated?

Your monthly bill is based on what you owe for any prescriptions you get, plus your previous month's balance, divided by the number of months left in the year.

Your payments might change every month, so you might not know what your exact bill will be ahead of time. Future payments might ~~increase~~ when you fill a new prescription or refill an ~~existing~~ prescription because as new out-of-pocket costs are added into your monthly payment, there are fewer months left in the year to spread out your payments. You'll never pay any interest or fees on the amount you owe, even if your payment is late.

Remember, in a single calendar year (Jan – Dec), you'll never pay more than:

- The total amount you would have paid out of pocket to the pharmacy.
- The Medicare drug coverage annual out-of-pocket maximum (which is $2,000 in 2025).

What happens if I don't pay my bill?

We'll send you a reminder if you miss a payment. If you don't pay your bill by the date listed in that reminder, you'll be removed from the Medicare Prescription Payment Plan. Like any other debt, ~~you're~~

~~required to~~ pay the amount you owe. Always pay your <plan name> premium first (if you have one), so you don't lose your drug coverage.

If you think that we've made a mistake with the amount you owe, call us at <phone number>. You also have the right to follow the grievance process found in your <insert "Member Handbook" or "Evidence of Coverage," as appropriate>.

Can I leave the Medicare Prescription Payment Plan?

You can leave the Medicare Prescription Payment Plan at any time by calling us at <phone number>. If you still owe a balance, ~~you're required to~~ pay the amount you owe, even though you're no longer ~~participating~~ in the program. You can choose to pay the remaining amount all at once or be billed monthly. If you leave, your Medicare drug coverage and other Medicare benefits won't be affected, and you'll go back to paying the pharmacy directly for all your out-of-pocket drug costs.

If you leave <current plan name> or change to a new Medicare drug plan or Medicare health plan with drug coverage (like a Medicare Advantage Plan) ~~your participation in~~ the Medicare Prescription Payment Plan ~~will end.~~ If you change plans, and you'd like to join the Medicare Prescription Payment Plan offered through your new plan, contact your new plan.

Are there programs that can help lower my costs?

While the Medicare Prescription Payment Plan spreads out your costs, it doesn't lower them. However, you may be ~~eligible for~~ programs that can help lower your costs, like:

- **Extra Help:** A Medicare program that helps pay your Medicare drug costs if you have limited income and resources. Visit secure.ssa.gov/i1020/start to find out if you qualify and apply. You can also apply with your state's Medicaid office. Visit Medicare.gov/basics/costs/help/drug-costs to learn more.
- **Medicare Savings Program**: A state-run program that helps people with limited income and resources pay some or all of their Medicare premiums, deductibles, and coinsurance. Visit Medicare.gov/medicare-savings-programs to learn more.
- **State Pharmaceutical Assistance Program (SPAP):** A program that may include coverage for your Medicare drug plan premiums and/or cost sharing. SPAP contributions may count toward your Medicare drug coverage out-of-pocket limit. Visit go.medicare.gov/spap to learn more.
- **Manufacturer's Pharmaceutical Assistance Programs** (sometimes called Patient Assistance Programs (PAPs)): A program from drug manufacturers to help lower drugs costs for people with Medicare. Visit go.medicare.gov/pap to learn more.

Many people qualify for savings and don't realize it. Visit Medicare.gov/basics/costs/help, or contact your local Social Security office to learn more. Find your local Social Security office at secure.ssa.gov/ICON/main.jsp or call 1-800-772-1213. TTY users can call 1-800-325-0778.

Exhibit 2 – Part D Sponsor Initial Notice for Failure to Make Payments under the Medicare Prescription Payment Plan

Referenced in [insert draft part 2 guidance section]

<Part D sponsors may insert a title for the notice, such as "Urgent: Pay your Medicare Prescription Payment Plan bill">

<Member #>

<RxID>

<RxGroup>

<RxBin>

<RxPCN>

Dear < Member>:

We didn't get your monthly payment for the Medicare Prescription Payment Plan that was due <insert payment due date>. To stay in the Medicare Prescription Payment Plan, you must pay <insert the full amount or a partial amount(s) ~~should the plan choose to allow enrollees to~~ pay the balance over separate payments> by <insert date for the end of the grace period (i.e., the date that is two calendar months from the first day of the month for which the balance is unpaid or the first day of the month following the date on which the payment is requested, whichever is later)>.

This letter only applies to your participation in the Medicare Prescription Payment Plan. Your Medicare drug coverage and other Medicare benefits won't be affected, and you'll continue to be enrolled in <plan name> for your drug coverage.

How do I pay my bill?

You can choose to pay the amount you owe all at once or be billed monthly. You'll never pay any interest or fees on the amount you owe.

You owe <insert unpaid>. You can pay:

- Online at <plan's website>, by credit/debit card.
- Through the mail, by check.
- <insert other payment methods offered by the plan like electronic funds transfer (including automatic charges of an account at a financial institution or credit or debit card account)>.

If you have questions about your payment, call us at <phone number>, <days and hours of operation>. TTY users can call < TTY number>.

What happens if I don't pay my bill?

If you don't pay your bill by <insert effective date>, you'll no longer be in the Medicare Prescription Payment Plan through <plan sponsor>. As of <effective date>, you'll pay the pharmacy directly for your out-of-pocket drug costs.

Like any other debt, ~~you're required to~~ pay the amount you owe. As long as you ~~continue to pay~~ your plan premium (if you have one), you'll still have drug coverage through <plan name>.

What if I think there's been a mistake?

If you think that we've made a mistake, call us at <phone number>. You also have the right to ask us to reconsider our decision through a grievance process. Check your <insert "Member Handbook" or "Evidence of Coverage," as appropriate>.

What if I can't afford to pay both my plan premium and my Medicare Prescription Payment Plan payment?

Always pay your <plan name> premium first (if you have one). If needed, we can apply a payment you've made toward your **Medicare Prescription Payment Plan** balance to your plan premium instead. Call us at <phone number> to discuss this option.

Are there programs that can help lower my costs?

While the Medicare Prescription Payment Plan spreads out your costs, it doesn't lower them. However, you may be ~~eligible for~~ programs that can help lower your costs, like:

- **Extra Help:** A Medicare program that helps pay your Medicare drug costs if you have limited income and resources. Visit secure.ssa.gov/i1020/start to find out if you qualify and apply. You can also apply with your state's Medicaid office. Visit Medicare.gov/basics/costs/help/drug-costs to learn more.
- **Medicare Savings Program**: A state-run program that helps people with limited income and resources pay some or all of their Medicare premiums, deductibles, and coinsurance. Visit Medicare.gov/medicare-savings-programs to learn more.
- **State Pharmaceutical Assistance Program (SPAP):** A program that may include coverage for your Medicare drug plan premiums and/or cost sharing. SPAP contributions may count toward your Medicare drug coverage out-of-pocket limit. Visit go.medicare.gov/spap to learn more.
- **Manufacturer's Pharmaceutical Assistance Programs** (sometimes called Patient Assistance Programs (PAPs)): A program from drug manufacturers to help lower drugs costs for people with Medicare. Visit go.medicare.gov/pap to learn more.

Many people qualify for savings and don't realize it. Visit Medicare.gov/basics/costs/help, or contact your local Social Security office to learn more. Find your local Social Security office at secure.ssa.gov/ICON/main.jsp or call 1-800-772-1213. TTY users can call 1-800-325-0778.

Note: The programs listed above can help lower your costs, but they can't help you pay off your Medicare Prescription Payment Plan balance.

~~Consider Managing~~ Your Monthly Drug Costs with the Medicare Prescription Payment Plan

~~You might benefit from participating in the Medicare Prescription Payment Plan, because you have high drug costs.~~ This new payment option works with your current drug ~~coverage, and it can help you manage your drug costs by spreading them across~~ **monthly payments that vary throughout the year** ~~(January – December).~~

What's the Medicare Prescription Payment Plan?

The Medicare Prescription Payment Plan is a new payment option to help you manage your out-of-pocket drug costs, starting in 2025. All Medicare drug plans and Medicare health plans with drug coverage (like a Medicare Advantage Plan) must offer this payment option, and all plans use the same formula to calculate your monthly payments. If you select this payment option, each month you'll pay your plan premium (if you have one) and you'll get a bill from your health or drug plan for your prescription drugs (instead of paying the pharmacy).

~~**Participating in**~~ **this payment option is** ~~**voluntary.**~~ Anyone with a Medicare drug plan or a Medicare health plan with drug coverage can use this payment ~~option, which applies to~~ all prescription drugs covered by Part D. It doesn't cost anything to ~~participate in~~ the Medicare Prescription Payment ~~Plan, and~~ you won't pay any interest or fees on the amount you owe, even if your payment is late.

Will this payment option help me?

It depends on your situation. If you have high out-of-pocket drug costs, this payment option spreads out what you'll pay each month across the year (January – December), so you don't have to pay out-of-pocket costs to the pharmacy. **This payment option might help you manage your expenses, but it doesn't save you money or lower your drug costs.** Visit Medicare.gov/basics/costs/help/drug-costs to learn about programs that can help lower your drug costs.

How will my costs work with this payment option?

The new prescription drug law caps your out-of-pocket costs at $2,000 in 2025 and ~~eliminates~~ the coverage gap (known as the "donut hole"). This means you'll never pay more than $2,000 in out-of-pocket drug costs in 2025. **This is true for everyone with Medicare drug coverage, even if you don't join the Medicare Prescription Payment Plan.**

When you fill a prescription for a drug covered by Part D, you won't pay your pharmacy (including mail-order and specialty pharmacies). Instead, you'll get a bill each month from your plan. Your monthly bill is based on what you owe for any prescriptions you get, plus your previous month's balance, divided by the number of months left in the year.

Note: Your payments might change every month, so you might not know what your exact bill will be ahead of time. Future payments might ~~increase~~ when you fill a new prescription or refill ~~an existing~~ prescription because as new out-of-pocket drug costs are added into your monthly payment, there are fewer months left in the year to spread out your payments.

How do I know if this payment option might not be right for me?

This payment option might not be helpful for you if:

- You get Extra Help from Medicare.
- You qualify for a Medicare Savings Program.

- You get help paying for your drugs from other organizations, like a State Pharmaceutical Assistance Program (SPAP) or other health coverage.
- Your yearly drug costs are low.
- Your drug costs are the same each month.
- You're ~~considering~~ signing up for the payment option late in the calendar year (after September).
- You don't want to change how you pay for your drugs.

Who can help me decide if I should sign up for this payment option?

- **Your plan:** Visit your plan's website, or call your plan to get more information. Your plan's phone number is on the back of your membership card.
- **Medicare:** Visit Medicare.gov/tbd, or call 1-800-MEDICARE (1-800- 633-4227), 24 hours a day, 7 days a week. TTY users can call 1-877-486-2048.
- **State Health Insurance Program (SHIP):** Visit shiphelp.org to get the phone number for your local SHIP and get free, personalized health insurance counseling.

How do I sign up for this payment option?

To sign up for this payment option, visit your plan's website or call your plan. You can find your plan's phone number on the back of your membership card. If you need to pick up a prescription ~~urgently~~, the fastest way to use this payment option is to call your plan.

Need this information in another format or language?

To get this material in other formats like large print, braille, or another language, contact your Medicare drug plan. If you need help contacting your plan, call: 1-800-MEDICARE (1-800-633-4227).

Exhibit 3 - Part D Sponsor Notice for Failure to Make Payments under Medicare Prescription Payment Plan - Notification of Termination of Participation in the Medicare Prescription Payment Plan

Referenced in [insert draft part 2 guidance section]

<Part D sponsors may insert a title for the notice, such as "Important: Your participation in the Medicare Prescription Payment Plan has ended">

<Member #>

<RxID>

<RxGroup>

<RxBin>

<RxPCN>

<Date>

Dear < Member>,

On <date of initial notification of failure to pay>, we sent you a letter letting you know your monthly payment for the Medicare Prescription Payment Plan was overdue. The letter explained that if you didn't make your payment by <insert time frame>, ~~we'd end your participation in~~ the Medicare Prescription Payment Plan.

~~Starting <insert effective date, which should be the same date as this letter>, you're no longer participating in the Medicare Prescription Payment Plan through <plan sponsor> because we didn't get your monthly payment. Like any other debt, you're still required to pay the amount you owe, $<amount owed>.~~

~~As of <effective date>, you'll pay the pharmacy directly for all your out-of-pocket drug costs.~~

This letter only applies to your participation in the Medicare Prescription Payment Plan. Your Medicare drug coverage and other Medicare benefits ~~won't be affected, and you'll continue to be~~ enrolled in <plan name> for your drug coverage.

How do I pay my balance?

You can choose to pay the amount you owe all at once or be billed monthly. You'll never pay any interest or fees on the amount you owe.

You owe <insert unpaid>. You can pay:

- Online at <plan's website>, by credit or debit card.
- Through the mail, by check.
- <insert other payment methods offered by the plan sponsor like electronic funds transfer (including automatic charges of an account at a financial institution or credit or debit card account)>.

If you have questions about your payment, call us at <phone number>, <days and hours of operation>. TTY users can call <TTY number>.

What if I think there's been a mistake?

If you think that we've made a mistake, call us at <phone number>. You also have the right to ask us to reconsider our decision through the grievance process in your <insert "Member Handbook" or "Evidence of Coverage," as appropriate>.

Can I use this payment option in the future?

Yes, once you pay the total amount you owe.

Are there programs that can help lower my costs?

You may be eligible for programs that can help lower your costs, like:

- **Extra Help:** A Medicare program that helps pay your Medicare drug costs if you have limited income and resources. Visit secure.ssa.gov/i1020/start to find out if you qualify and apply. You can also apply with ~~your state's~~ Medicaid office. Visit Medicare.gov/basics/costs/help/drug-costs to learn more.
- **Medicare Savings Program**: A state-run program that helps people with limited income and resources pay some or all of their Medicare premiums, deductibles, and coinsurance. Visit Medicare.gov/medicare-savings-programs to learn more.
- **State Pharmaceutical Assistance Program (SPAP):** A program that may include coverage for your Medicare drug plan premiums and/or cost sharing. SPAP contributions may count toward your Medicare drug coverage out-of-pocket limit. Visit go.medicare.gov/spap to learn more.
- **Manufacturer's Pharmaceutical Assistance Programs** (sometimes called Patient Assistance Programs (PAPs)): A program from drug manufacturers to help lower drugs costs for people with Medicare. Visit go.medicare.gov/pap to learn more.

Many people qualify for savings and don't realize it. Visit Medicare.gov/basics/costs/help, or contact your local Social Security office to learn more. Find your local Social Security office at secure.ssa.gov/ICON/main.jsp or call 1-800-772-1213. TTY users can call 1-800-325-0778.

Note: The programs listed above can help lower your costs, but they can't help you pay off your Medicare Prescription Payment Plan balance.

Exhibit 4 - Part D Sponsor Notification of Voluntary Removal from the Medicare Prescription Payment Plan

Referenced in [insert draft part 2 guidance section]

<Part D sponsors may insert a title for the notice, such as "You're no longer participating in the Medicare Prescription Payment Plan through <plan sponsor>">

<Member #>

<RxID>

<RxGroup>

<RxBin>

<RxPCN>

Dear <Member>,

Starting <insert effective date>, you're no longer ~~participating~~ in the Medicare Prescription Payment Plan through <plan sponsor>. As of <effective date>, you'll pay the pharmacy directly for your out-of-pocket drug costs.

You're getting this letter because you either asked to stop ~~participating in~~ this payment option, **or** you changed your Medicare drug plan or Medicare health plan with drug coverage (like a Medicare Advantage Plan). If you changed plans, and you'd like to join the Medicare Prescription Payment Plan offered through your new plan, contact your new plan.

This letter only applies to your participation in the Medicare Prescription Payment Plan. Your Medicare drug coverage and other Medicare benefits won't be affected, and you'll continue to be enrolled in <plan name> for your drug coverage.

How do I pay my balance?

You can choose to pay the amount you owe all at once or be billed monthly. You'll never pay any interest or fees on the amount you owe, even if your payment is late.

You owe <insert unpaid>. You can pay:

- Online at <plan's website>, by credit or debit card.
- Through the mail, by check.
- <insert other payment methods offered by the plan sponsor like electronic funds transfer (including automatic charges of an account at a financial institution or credit or debit card account)>.

If you have questions about your payment, call us at <phone number>, <days and hours of operation>. TTY users can call <TTY number>.

What happens if I don't pay my balance?

Like any other debt, ~~you're required to~~ pay the amount you owe. As long as you ~~continue to pay~~ your plan premium (if you have one), you'll still have drug coverage.

Can I use this payment option in the future?

- **If you're still in <plan name>:** Yes. Visit <insert PDP webpage where the application is>, or call us at <phone number> <days and hours of operation>. TTY users can call <TTY number>.
- **If you're joining a new plan:** Yes. All Medicare drug plans and Medicare health plans with drug coverage must offer this payment option. No matter what Medicare drug plan you're in, you can choose to rejoin the Medicare Prescription Payment Plan at any time.

Are there programs that can help lower my costs?

You may be ~~eligible for~~ programs that can help lower your costs, like:

- **Extra Help:** A Medicare program that helps pay your Medicare drug costs if you have limited income and resources. Visit secure.ssa.gov/i1020/start to find out if you qualify and apply. You can also apply with your state's Medicaid office. Visit Medicare.gov/basics/costs/help/drug-costs to learn more.
- **Medicare Savings Program**: A state-run program that helps people with limited income and resources pay some or all of their Medicare premiums, deductibles, and coinsurance. Visit Medicare.gov/medicare-savings-programs to learn more.
- **State Pharmaceutical Assistance Program (SPAP):** A program that may include coverage for your Medicare drug plan premiums and/or cost sharing. SPAP contributions may count toward your Medicare drug coverage out-of-pocket limit. Visit go.medicare.gov/spap to learn more.
- **Manufacturer's Pharmaceutical Assistance Programs** (sometimes called Patient Assistance Programs (PAPs)): A program from drug manufacturers to help lower drugs costs for people with Medicare. Visit go.medicare.gov/pap to learn more.

Many people qualify for savings and don't realize it. Visit Medicare.gov/basics/costs/help, or contact your local Social Security office to learn more. Find your local Social Security office at secure.ssa.gov/ICON/main.jsp or call 1-800-772-1213. TTY users can call 1-800-325-0778.

Note: The programs listed above can help lower your costs, but they can't help you pay off your Medicare Prescription Payment Plan balance.