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August 25, 2025

The Honorable Dr. Mehmet Oz, Administrator
Centers for Medicare and Medicaid Services
Department of Health and Human Services
200 Independence Avenue SW
Washington, DC 20201

Subject: CMS-10882; OMB 0938-1475; Part C and Part D Medicare Prescription Payment Plan Model Documents

Dear Administrator Oz:

I am writing on behalf of Paytient in response to an Information Collection Notice published in the Federal Register on July 28, 2025 entitled *Part C and Part D Medicare Prescription Payment Plan Model Documents*. In addition to the revised model plan documents issued in this notice, we believe there are three no-cost approaches that CMS can consider to increase participation in the Medicare Prescription Payment Plan for the 2026 calendar year. We also believe a change in the method for incorporating plans' outreach and implementation of the program into the medical loss ratio calculation can help strengthen access to the Medicare Prescription Payment Plan. We welcome an opportunity to work with your administration to bring this important program to more Medicare beneficiaries who are struggling to meet their prescription care needs.

About Paytient

Paytient is a healthcare affordability platform founded in 2018 in Columbia, Missouri. The company is on a mission to help Americans better access and afford care. By ensuring patients are able to pay for care we are lowering cost as a barrier, empowering better and healthier patient decision making; reducing the profiteering steerage of middlemen, removing the cancer of uncompensated care from our health system, ensuring providers are paid fairly, timely, and fully at time of service, and restoring dignity and freedom of individual patients to be the rightful decision-maker and value holder of their own health. Paytient is purposefully built and engineered to help MainStreet America pay for care - without interest or fees.

Paytient collaborates and integrates with numerous prominent employers, payers, providers, and pharmacy benefit managers nationwide to ensure affordability for services not covered by insurance, guarantee immediate payment to healthcare providers, and enhance overall plan performance for employers and insurers. This payment technology is strategically deployed across the United States within various segments of the healthcare ecosystem, including but not limited to, Affordable Care Act (ACA) plans, Group Health Plans, Alternative Health Plans, Pharmacy services, Specialty care, and Medicare.

Paytient is currently collaborating with Aetna, Elevance Health, Express Scripts, multiple Blue plans, Cigna, Centene, HealthEquity, Humana, UnitedHealth/Optum, and Zelis, making our software the backbone of the Medicare Prescription Payment Plan for 40 percent of the Part D market. Nearly 23 million Americans and Medicare beneficiaries have a health plan that is empowered by Paytient's tools and we maintain an industry-leading net promoter score of more than 85.

Our Proposal

To address the unexpectedly low participation rates in the first year of the Medicare Prescription Payment

Plan, we recommend that CMS issue updated program instructions or guidance in anticipation of the second program year beginning in January 2026 and consider three approaches that can be implemented without incurring additional program costs:

1. *Clarify Participation Benchmarks:* Issue guidance to Part D plans that sets an expected minimal participation benchmark (e.g., 5 percent) of eligible Part D enrollees.

2. *Public Reporting of Plan Effectiveness:* Issue a statement of intent to publish public reports ranking Part D Plan sponsors based on the effectiveness of their outreach and notification efforts, as measured by the participation benchmark, starting in 2026.

3. *Leverage Private Market Innovation and Technology:* Issue an opinion encouraging Part D plans to use private market innovation and technology to enable beneficiaries to opt in at the point-of-service, thereby reducing administrative burdens and delays for the 2026 plan year.

These no-cost modifications to guidance have the potential to significantly improve the effectiveness of CMS's implementation of Section 11202 of the Inflation Reduction Act and will not require any action from Congress or any additional costs to the program. Most importantly, these tactics will ensure that Medicare beneficiaries receive the intended financial benefits of this program.

We explain in more detail below how CMS can pursue these approaches either independently or alternatively to grow the Medicare Prescription Payment Plan to reach its intended goal of saving seniors money on their monthly prescriptions. We also provide detail on our request for CMS to adjust the medical loss ratio calculation to better account for the costs associated with plans' outreach and implementation of the payment plan.

Medicare Beneficiaries Need More Outreach

Prior to program implementation, the projected estimates of eligible Part D enrollees that would be likely to benefit from the Medicare Prescription Payment Plan ranged between 6 and 8 percent based upon the approach outlined in the CMS guidance. Yet, current 2025 observed participation rates indicate the population that will benefit in the first year of the program will be as low as 0.4 to 0.6 percent of the eligible population. A participation rate that represents less than 10 percent of estimates suggests an opportunity to address guidance in a manner that yields results consistent with expectations. When CMS issued the first guidance document to Part D plans in February 2024, it acknowledged that "through program experience, CMS will gain a better understanding of which Part D enrollees are likely to opt into the program and will make modifications as appropriate and necessary in the future." We believe the modification options presented in this document are appropriate and necessary for the upcoming program year, given the much lower than expected participation rate in 2025.

Paytient believes the participation discrepancy could be attributed to the current method for discerning who is likely to benefit, which could have examined Medicare beneficiaries' total monthly medication costs rather than being focused on whether the individual had a single prescription with an out-of-pocket cost greater than the applicable threshold amount during that month. Paytient is interested in exploring potential alternatives to parsing the likely to benefit data to implement changes in future plan years, but before the start of the Part D plan year in 2026 there are less burdensome steps CMS can take to increase enrollee outreach and participation.

Three Approaches to Consider for 2026

Without additional costs or the need for legislative action, CMS can use its discretion afforded by Section 11202(c) of the Inflation Reduction Act to remedy the very low uptake of the Medicare Prescription Payment Plan by implementing any or all of the three approaches we present here.

First, CMS could issue guidance clarifying to Part D plans an expected ***minimal benchmark*** (e.g. 5

percent opt-in of enrollees Likely to Benefit) that would stand as evidence of a plan's effective outreach and notification to eligible Part D enrollees that are likely to benefit. This benchmark would provide Part D plan sponsors with an incentive to demonstrate a good faith effort in partnering with CMS to achieve affordability for Part D enrollees. The expected *minimal benchmark* is an example of effectively leveraging transparency to improve program effectiveness. It also adds accountability for each plan's stewardship not only of Medicare funds but of their consumers' own out-of-pocket costs.

Second, CMS could issue instructions for plan year 2026 outlining its intent to issue ***public reports*** of Part D plan sponsors in rank order of the effectiveness of outreach and notification efforts. In an era of high-cost health care, calls for transparency, and increased focus on protecting the federal budget from overspending, an annual public report would give high-performing Part D plan sponsors well-deserved public recognition for taking the necessary steps to address affordability and reduce waste through effective outreach and notification. In addition, these public reports would allow best practices to emerge that can be disseminated across Part D plan sponsors. With the development and deployment of best practices, Part D plans would be able to accelerate program participation to achieve CMS' initial estimates of participation in the payment plan. This is a key example of utilizing transparency to improve program impact in a meaningful, straightforward manner.

Third, for Part D enrollees with high out-of-pocket costs who are likely to benefit from program participation, CMS could revise its guidance to explicitly **endorse and encourage technology** that streamlines administrative tasks at the point-of-service for more efficient opt-ins. By leveraging technology, CMS would simultaneously improve implementation effectiveness and lower costs while improving overall program satisfaction for Part D enrollees. The prior CMS instructions and guidance did not take into consideration new technology solutions as part of its implementation process, yet new technology is a more effective manner of program deployment than relying solely on legacy infrastructure. Given your administration's strong focus on leveraging technology to improve health care, including artificial intelligence and data exchange, we believe CMS can use the Medicare Prescription Payment Plan as an incubator for innovators to pilot new technology tools that help improve beneficiaries' customer experience while at the same time cutting administrative costs for Part D plans and the Medicare program overall. This recommendation reflects a forward-leaning approach to effective program deployment.

Additional Request: Reconsider Medical Loss Ratio Calculation

Because affordability challenges are linked to medication adherence and higher total cost of care, failure to resolve the issue of low Medicare Prescription Payment Plan participation is likely to lead to waste and poor health outcomes as Part D enrollees receive less effective medication management and have a higher likelihood of avoidable hospital admissions. In fact, it is for this reason that Paytient strongly believes the costs of administering the Medicare Prescription Payment Plan should appropriately be categorized as medical and quality improvement care costs in the calculation of a Part D plan's medical loss ratio (MLR), rather than as simple administrative costs.

Medicare plans are held to quality standards under several HEDIS measures for their enrollees' medication adherence for hypertension, diabetes, and cholesterol control medications. Plans are also measured on their ability to provide enrollees with medication therapy management or MTM when those enrollees have multiple prescriptions for chronic health conditions that require close consultation with a pharmacist. The Medicare Prescription Payment Plan was meant as a scaffolding to support the Part D plans efforts in these areas, yet plans were directed in the Part Two program guidance to treat costs and balances due under the payment plan as administrative costs when calculating the plan's MLR. We believe this is misplaced.

Medical acuity and quality outcomes are both significantly improved for beneficiaries that have the support of the Medicare Prescription Payment Plan to continue purchasing and taking their physician-ordered medications. This should place the costs of the Part D plan for payment plan outreach, enrollment, and facilitation on the medical and quality sides of the MLR equation and not the administrative side. The current guidelines for calculating MLR in this way might actually be contributing

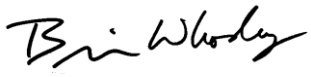
to the low uptake of the program since Part D plans have a disincentive to spend the necessary funds to promote the program within their population and reach those that are likely to benefit from this financial management option. We encourage CMS to reconsider this approach and issue program guidance to permit Medicare Prescription Payment Plan costs to be part of the plan's MLR rather than being characterized as an administrative cost.

Conclusion

In conclusion, the previous program instructions and guidance provided by CMS set a foundation for the Medicare Prescription Payment Plan implementation, but the current implementation is falling 90 percent below expectations. As Section 11202(c) affords CMS the discretion to remedy this situation by issuing new guidance in time for the 2026 calendar year, we encourage CMS to consider the approaches outlined in this letter to immediately address medication affordability for an estimated 8 million Part D enrollees by adding accountability standards, publishing information on each plan's efforts, and leveraging transparency and technology. We also ask CMS to reconsider its guidance to plans related to calculation of the MLR, since the direct benefit of an enrollee's participation in the program and continued medication adherence is a reduction in chronic care needs exacerbation and an increase in the plan's quality measure scores.

Thank you for your attention to this matter. We look forward to your response and are available to discuss these recommendations further.

Sincerely,



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