June 24, 2024

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

Dear Administrator Brooks-LaSure,

Submitted via http://www.regulations.gov/

RE: Medicare Part D Reporting Requirements (CMS-10185 and CMS-10008)

The MAPRx Coalition appreciates the opportunity to provide the Centers for Medicare & Medicaid Services (CMS) with comments regarding Medicare Part D Reporting Requirements, as requested in the notice published in the *Federal Register* on May 24, 2024,[1] revised from the original requirements published in the *Federal Register* on February 2, 2024.[2]

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 coalition strongly supports the implementation of the Medicare Prescription Payment Plan (MPPP) and the $2,000 out of pocket (OOP) cap, both of which will help ease beneficiary financial burdens for medications and make OOP costs more manageable and predictable. We believe data reporting from Part D plan sponsors is critical and will help CMS and the beneficiary community to evaluate the effectiveness of the program in reducing barriers to care and ensuring beneficiaries have access to needed therapies.

CMS updates to initial Part D Reporting Requirements

The MAPRx Coalition is pleased that CMS has made several important changes to the Part D Reporting Requirements, many of which the Coalition advocated for in our April 2 comments. Those changes include the following language from the revised ICR; CMS is proposing to include reporting:

A. Total number of individuals identified as likely to benefit during the reporting period based on one or more of the following methods: prior plan year criteria; during the plan year criteria; POS criteria, including those who did not elect to participate.
B. Total number of individuals identified as likely to benefit during the reporting period based on prior to plan year criteria, including those who did not elect to participate.

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[1] Centers for Medicare & Medicaid Services. Agency Information Collection Activities: Submission for OMB Review; Comment Request. *Federal Register*. May 24, 2024. Accessed June 14, 2024. https://www.federalregister.gov/d/2024-11397

[2] Centers for Medicare & Medicaid Services. Agency Information Collection Activities: Proposed Collection; Comment Request. Federal Register. February 2, 2024. Accessed March 27, 2024. https://www.federalregister.gov/d/2024-02095

C. Total number of individuals identified as likely to benefit during the reporting period based on during the plan year criteria, including those who did not elect to participate.
D. Total number of individuals identified as likely to benefit during the reporting period based on POS criteria, including those who did not elect to participate.
E. Among individuals identified in element A, the total number of those individuals who submitted an election request to participate in the MPPP during the reporting period.

While we appreciate the additions to the reporting requirements, we respectfully request that CMS augment the updated requirements with several additional data points. Specifically, we believe it is vital that CMS also require plans to report the following:

- Number of beneficiaries who opted into MPPP who were not identified as likely to benefit
    - Number of beneficiaries who opted into MPPP upon a plan enrollment
- Election methods
    - Number of beneficiaries who opted into MPPP following receipt of an election request form sent with a membership ID card
    - Number of beneficiaries who opted into MPPP via plan websites, telephone, fax/mail

We also appreciate the addition of the new measures for unsettled balances. However, we believe the following key data points related to the grace period and disenrollments will also be important in evaluating the MPPP:

- Number of MPPP participants who missed payments, including:
    - Number of MPPP participants with a missed payment who paid after receiving first notice of a late payment
    - Number of MPPP participants with a missed payment who paid after receiving second notice of a late payment

We appreciate CMS' consideration of these additional data points and thank the Agency for the changes that have been made from the original requirements that were published on February 2. We also would like to reiterate our support for adding the following to the Part D Reporting Requirements that were included in our April 2 comments.

Further refinements to the data collected from Part D plan sponsors
MAPRx believes it is essential that all beneficiaries are informed about the program, and we have consistently advocated that CMS, Part D plans, and pharmacies not restrict MPPP outreach only to those who meet the CMS threshold of most likely to benefit from MPPP. Beneficiary medication needs and costs change throughout the year for a variety of reasons and beneficiaries can incur significant OOP costs as a result of a single prescription or multiple different prescriptions. As a result, some beneficiaries who ultimately may benefit from MPPP will not take advantage of it simply because they were excluded from targeted outreach efforts and were unaware of the program. This underscores the need for CMS to require enhanced reporting, especially collecting data that can help the agency determine whether it has selected the right threshold for targeted outreach prior to the plan year, during the plan year and at the point of sale. We recommend CMS collect the following data:

- **$600 threshold**: In the finalized part one guidance, CMS stated it "…chose a $600, single prescription drug cost threshold because this approach strikes the best balance between identifying Part D enrollees with a very high likelihood (~98%) of benefiting from the

Medicare Prescription Payment Plan program, while reducing the risk of identifying Part D enrollees who will not meet the likely to benefit definition." However, CMS' own data also show that a lower threshold of $400 would result in targeting 2.9 million beneficiaries who "might" benefit and would result in informing 2,600,000 (90% success rate) who "actually" would benefit. In order to assess the degree to which the $600 threshold is appropriate, we recommend that CMS require Part D plans to report:

  - The number of beneficiaries who meet or exceed the $600 threshold and the number of beneficiaries who meet or exceed a $400 threshold
  - The number of beneficiaries who meet or exceed the $600 threshold and who opted into MPPP and the number of beneficiaries who meet or exceed a $400 threshold and who opted into MPPP
  - The number of beneficiaries who meet or exceed the $600 threshold and who did not opt into MPPP and the number of beneficiaries who meet or exceed a $400 threshold and who did not opt into MPPP

- **Single prescription drug costs**: In the finalized part one guidance, CMS also indicated that the threshold for determining who was very likely to benefit would be $600 in drug costs from a *single* prescription. As we noted in our comments to the draft part two guidance, Congress intended the MPPP and OPP cap to apply to cumulative beneficiary costs, not a single prescription cost. Therefore, additional data will help CMS assess whether its targeted approach to outreach is consistent with Congressional intent for the program. In order to assess the degree to which the single prescription threshold is appropriate, we recommend that CMS require Part D plans to report:
  - The number of beneficiaries who meet or exceed the $600 threshold with a single prescription and the number of beneficiaries who meet or exceed a $400 threshold with a single prescription
  - The number of beneficiaries whose cumulative drug costs meet or exceed the $600 threshold and who opted into MPPP, and the number of beneficiaries whose cumulative drug costs meet or exceed a $400 threshold and who opted into MPPP
  - The number of beneficiaries whose cumulative drug costs meet or exceed the $600 threshold and who did not opt into MPPP, and the number of beneficiaries whose cumulative drug costs meet or exceed a $400 threshold and who did not opt into MPPP

In addition to these important refinements, we believe it will be important to utilize MPPP data to help address any disparities within the Part D population. To help facilitate this specific assessment, it may be helpful for Part D plan sponsors—when within their ability—to provide demographic information of those enrolling and opting against enrollment into the MPPP. This data may include income level, geographic location, age, race/ethnicity, and sex.

Data availability and plan oversight

As we have noted in our April 2 comment letter, MAPRx appreciates CMS' efforts to require Part D plans to report data, and we recommend the reporting of additional data points that will allow the agency to assess the effectiveness of the MPPP program and Part D plan and pharmacy outreach and education efforts. We also strongly recommend that CMS make this data publicly available. The MAPRx coalition, our member organizations and other stakeholders such as prescribers, patient navigators, and State Health Insurance Assistance Programs play critical roles in educating and informing beneficiaries about Part D plan changes, such as the MPPP, the OOP cap, and expanded low-income subsidy eligibility. As such, this data can inform stakeholder education and outreach strategies, including strategies that can reach those beneficiaries who may be missed by outreach from Part D plans and pharmacies. This is especially important

considering CMS is not implementing a POS MPPP enrollment option in 2025 and may not implement an MPPP enrollment option on the Plan Finder tool.

Finally, we recognize that the proposed data reporting elements—including the data elements requested by our coalition and other patient groups—may be an administrative burden for Part D plan sponsors. We respectfully ask that CMS provide vigilant oversight of Part D plans to ensure they do not seek to pass this administrative burden onto patients in the form of greater access restrictions and higher premiums.

Thank you for your consideration of our comments. MAPRx appreciates CMS' efforts to engage our coalition and the broader beneficiary community as it implements these significant changes to Part D. Please contact Bonnie Hogue Duffy, Convener, MAPRx Coalition at (202) 540-1070 or bduffy@nvgllc.com, if you have any questions or if we can provide additional information.