

CMS Medicare Prescription Payment Plan Guidance Comment

This document is submitted by the Massachusetts Health Data Consortium (MHDC) and its Data Governance Collaborative (DGC) in response to the CMS Medicare Prescription Payment Plan Guidance Part 1 posted on the CMS website on August 21, 2023 and found here: <https://www.cms.gov/files/document/medicare-prescription-payment-plan-part-1-guidance.pdf>

About MHDC

Founded in 1978, MHDC, a not-for-profit corporation, convenes the Massachusetts's health information community in advancing multi-stakeholder health data collaborations. MHDC's members include payers, providers, industry associations, state and federal agencies, technology and services companies, and consumers. The Consortium is the oldest organization of its kind in the country.

MHDC provides a variety of services to its members including educational and networking opportunities, analytics services on both the administrative and clinical side (Spotlight), and data governance and standardization efforts for both clinical and administrative data (the Data Governance Collaborative/DGC and the New England Healthcare Exchange Network, respectively).

About DGC

The DGC is a collaboration between payer and provider organizations convened to discuss, design, and implement data sharing and interoperability among payers, providers, patients/members, and other interested parties who need health data. It is a one stop interoperability resource. The DGC primarily focuses on three areas:

1. Collaboration: Development of common understanding of and specifications for data standards, exchange mechanisms, and what it means to participate in the modern health IT ecosystem
2. Education: helping members understand their regulatory obligations, the data and exchange standards they're expected to use, and modern technology and related processes
3. Innovation: Identification and development of projects and services needed to make modern health data practices and exchange a reality

General Comments

This section includes general comments about the guidance document.

Price Transparency and Consistency

Our initial expectations were that a payment plan would be designed with 12 equal monthly payments to provide price transparency and predictability/consistency to enrollees. We realize this would either require everyone paying \$166.67/\$166.66 payments to reach \$2000.00 and a potential refund if the \$2000 threshold is not reached or some lower estimated total cost split evenly across the year with the potential to owe additional money if the total amount used ends up being higher than that paid via the payment plan, but this has several advantages to the enrollee:

1. Transparency/no surprise bills. It lets enrollees know what their payments will be ahead of time so they are not surprised by the amount they're asked to pay. The current scheme affords no insight into the expected payment ahead of time unless the enrollee sits down and calculates the payments themselves based on what they've actually filled at their pharmacy. Having transparency is important, especially since the price

at the pharmacy will be \$0 so they will be accepting the medication without knowing how they will be paying for it unless they know they'll go over the OOP maximum early on – even those enrollees who are certain they will eventually meet the OOP maximum and thus know their actual annual responsibility will not know how much they are signing up to pay each month, especially for individuals who expect most of their costs to come from maintenance drugs with a standard cost each month. This may dissuade some individuals who could otherwise benefit from the program from using it as it will make monthly budgeting difficult.

2. Consistency. For many people it is easier to absorb a standard monthly payment amount into their budgets as so many other payments are structured that way. This is especially true for seniors who may be living on standard monthly payments like Social Security payments and pension distributions. Having a standard amount to set aside for medications makes other purchasing decisions easier; knowing how much their drugs will cost will inform how much money they have available for other purchases.

Given the priority CMS has been giving to price transparency and eliminating surprise billing, the current plan seems a bit misaligned with other agency activity.

Also, if any of the educational or outreach materials discuss spreading the payments out across the year without going into detail, some people are going to assume that the payments are the same every month. An explicit note that for some participants the payments will probably go up as the year progresses may be appropriate and help them better understand if the program is right for them.

Notice of Likely Disadvantage for Participation

The draft guidance provides instructions for identifying Medicare Part D/Medicare Advantage enrollees who are likely to benefit from the payment plan, but because all enrollees are eligible and certain enrollee usage profiles would result in payment schedules likely less desirable than the default pay-as-you-go until you hit the OOP maximum scenario, participants in our Data Governance Collaborative felt that it was just as important to inform such patients that electing the program might be disadvantageous as it is to notify those patients likely to benefit from it so they can enroll.

For example, an enrollee with \$100 of maintenance drugs every month will not meet their out of pocket maximum during the year and will have even payments across the year in the default POS payment model. If they elect the payment plan this would no longer be true and their payments would get larger toward the end of the year, right at a time when many people have more expenses than at some other times of the year and are most likely to want lower drug costs. While they have the right to elect the plan (and perhaps even some have unusual financial circumstances that would make it a good choice for them), doing so has no obvious benefits and has potential negative consequences. This enrollee should be discouraged from electing the payment plan, or at least efforts should be made to ensure that any such choice is made only after being fully informed about the consequences.

There are many possible ways to do this. One option might be to estimate the enrollee's anticipated purchases based on their medication fills from the previous year if the data is available (with or without acute fills – we suggest that without might make more sense, although this may vary from enrollee to enrollee) and send them a personalized estimated payment plan for the year as part of their enrollment paperwork.

This type of estimate would likely be helpful to all enrollees – those most likely to benefit from the payment plan, those for whom it won't make too much difference, and those who might find it disadvantageous – and we recommend making it a standard part of the program for all enrollees regardless of their anticipated status.

These estimates should be clear that they are based on the previous year's purchases and are not guaranteed to be accurate, and also that unexpected additional medication purchases of any significant amount may greatly alter the payment schedule. It may be appropriate to indicate that the earlier in the year such events happen, the more likely it is that the payment plan would benefit the enrollee.

Real Time Election at Point of Sale

We believe that supporting real time election at the point of sale is important and should be adopted as soon as possible. Guidelines for recommending election at the point of sale based on current purchase amounts

should be developed alongside this feature, perhaps based on making a single purchase of at least \$X amount (perhaps variable by month) or reaching a total OOP maximum of \$Y (varying by month). We are not sure simple “one purchase of \$K” or “one day with \$J in total purchases” is nuanced enough to be effective for individual selection, especially as the timeframe of the purchase can make a huge difference (see below).

Threshold for Identifying Enrollees Who Might Benefit

Participants in our Data Governance Collaborative agree that a payment plan where all of the monthly payments are lower than the anticipated monthly payments for maintenance medications paid for at the time of sale is a reasonable loose threshold for determining in advance of a plan year whether an enrollee is likely to benefit from the payment plan program.

It is less clear how to consider any unexpected, acute prescriptions as they are, by definition, not predictable in advance. We are inclined either to disregard such charges in the pre-plan year recommendation process or possibly average the acute payments accrued throughout the previous 2-3 years if such data is available, perhaps adding it to a middle of year month in the calculations.

We acknowledge the discussion in the guidance document around looking at either the cost of a single drug or a single day’s cumulative purchase for determining a threshold for recommending election after the start of a plan year. As noted in a previous comment, we are not certain it is nuanced enough to be effective, particularly if the same thresholds are used throughout the plan year. At a minimum, we suggest that any plan using this mechanism differentiate between 30 day and 90 day supply purchases and evaluate when 90 day supplies are purchased throughout the year. Whether there are refills/it’s a drug that patients typically use on an ongoing basis vs for a short period of time may also make a big difference in that they can help estimate whether a one time charge is likely to be repeated in the future.

For example, going on a payment plan for a \$400 purchase for a 90 day supply of a maintenance drug may or may not make sense if that’s the only purchase made throughout the year. The exact months during which the purchases are made make a difference. As noted in the table below, someone incurring \$400 for a 90 day supply in January, April, July, and October will likely benefit from the plan under most reasonable criteria (although some people might prefer to pay the four \$400 fees so they don’t owe any money in November and December when expenses tend to be higher for many people). Someone incurring \$400 for a 90 day supply in February, May, August, and November may benefit somewhat in that none of their payments will exceed \$400, but will have more than 75% of their annual costs in the last five months of the year and nearly half of their annual costs in the last two months of the year when expenses tend to be higher so it may not be a good fit for everyone. Someone incurring \$400 for a 90 day supply in March, June, September, and December would pay almost the entire bill in the second half of the year and have an almost \$600 payment in December - likely an unfavorable outcome.

Month	New charges/payment	New charges/payment	New charges/payment
January	\$400/\$166.67	\$0/\$0	\$0/\$0
February	\$0/\$21.21	\$400/\$36.36	\$0/\$0
March	\$0/\$21.21	\$0/\$36.36	\$400/\$40
April	\$400/\$65.66	\$0/\$36.36	\$0/\$40
May	\$0/\$65.66	\$400/\$86.37	\$0/\$40
June	\$0/\$65.66	\$0/\$86.36	\$400/\$97.14
July	\$400/\$132.32	\$0/\$86.37	\$0/\$97.14
August	\$0/\$132.32	\$400/\$166.37	\$0/\$97.14
September	\$0/\$132.32	\$0/\$166.37	\$400/\$197.15
October	\$400/\$265.66	\$0/\$166.36	\$0/\$197.14
November	\$0/\$265.66	\$400/\$366.36	\$0/\$197.15
December	\$0/\$265.65	\$0/\$366.36	\$400/\$597.14
Total Paid	\$1600	\$1600	\$1600

Thus, recommending enlisting in the payment plan based on a \$400 purchase in March (and perhaps even February) could lead to an unfavorable outcome for the enrollee.

Prefunded Pharmacy Cards

Participants in our Data Governance Collaborative universally agree that offering a prefunded pharmacy card is the best way to handle ensuring that pharmacies are properly and promptly paid for the patient component of drug purchase price. We recognize the various potential difficulties outlined by CMS in the draft guidance document, but note that nearly all of them also apply to HSA and 125 Cafeteria Plans where such cards are commonplace. We will address a few of them directly:

1. Card used for unauthorized purchases – enrollees are responsible for ensuring that they only use the card for the approved purpose and to purchase the covered prescription drugs. Any purchases that do not fall under this category must be reimbursed by the enrollee. This could be added to the next bill as an additional charge that is outside of the maximum allowed payment, go to collections if necessary, etc. They are also responsible for reporting lost or stolen cards in a timely manner. All of this should be pretty standard for any type of payment card.
2. Participant may forget a physical card – most retail pharmacies allow their customers to put a credit or debit card on file for use without the physical card. This option could be used to limit the effects of forgetting to bring the card to the pharmacy. A secondary billing option equivalent to the current plan could be also be used as a backup or plans could be required to reimburse enrollees (perhaps limited to no more than twice a year?) using the same process outlined in the current guidance for required reimbursements.
3. Participant cannot use the program until a card is received. Participants could be given a temporary number that's good for 14 days that they could put on file at their pharmacy on a temporary basis and replace with their permanent information once it's available. A secondary billing option equivalent to the current plan could be also be used until such time as the card is received or the plans could be required to reimburse enrollees for charges incurred in the first up to N days using a process like the current emergency reimbursement or payer fault reimbursements outlined in the current guidance.
4. Organizational readiness – there are vendor programs and existing banks that manage these sorts of programs that could easily be adopted to the Medicare payment plan program if desired. This would limit the need for new institutional knowledge around the use of these cards inside payer organizations.