American Kidney Fund®
FIGHTING ON ALL FRONTS

September 20, 2023

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

Re: Maximum Monthly Cap on Cost-Sharing Payments Under Prescription Drug Plans: Draft Part One Guidance on Select Topics, Implementation of Section 1860D-2 of the Social Security Act for 2025, and Solicitation of Comments

Dear Deputy Administrator Seshamani:

The American Kidney Fund appreciates the opportunity to provide comments on the Centers for Medicare and Medicaid Services' (CMS) draft part one guidance on the Medicare Prescription Payment Plan.

The American Kidney Fund (AKF) fights kidney disease on all fronts as the nation's leading kidney nonprofit. AKF works on behalf of the 37 million Americans living with kidney disease, and the millions more at risk, with an unmatched scope of programs that support people wherever they are in their fight against kidney disease—from prevention through transplant. Through programs of prevention, early detection, financial support, disease management, clinical research, innovation and advocacy, no kidney organization impacts more lives than AKF. AKF is one of the nation's top-rated nonprofits, investing 97 cents of every donated dollar in programs, and holds the highest 4-Star rating from Charity Navigator and the Platinum Seal of Transparency from GuideStar.

AKF is a strong supporter of the Medicare Prescription Payment Plan, which when combined with the true out-of-pocket cap (OOP) for Part D coverage, will help alleviate the financial burden for beneficiaries with significant prescription drug needs. This includes beneficiaries with chronic kidney disease, many of whom also have other comorbidities and need access to Part D-covered medications to manage their conditions.

We offer the following comments on certain issues in this draft part one guidance.

Program Calculations

AKF appreciates the detailed calculations and scenarios provided in the draft guidance, as they help illustrate the maximum monthly cap and monthly participant payment for different incurred OOP costs and how they may vary during the year. However, given the complexity of the calculations, we recommend CMS consider simplifying this information as it develops education

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materials for beneficiaries that explain the program calculations. Specifically, we recommend CMS clearly explain to beneficiaries that while their monthly payments may vary depending on different factors, their total OOP costs for the entire plan year will not exceed $2,000. We also suggest that beneficiary educational materials focus on a simple month-to-month total of what their OOP obligations are and exclude the maximum monthly cap column that is in the draft guidance, to minimize confusion.

Participant Billing Requirements

AKF appreciates that CMS encourages plans to offer multiple means of payment and to offer participants flexibility around requesting a specific day of the month for program charges and withdrawals from a bank account. However, we recommend CMS require plans to offer flexibility on billing timing and offer multiple means of payment, including electronic funds transfer, automated payments, credit card, cash, and check. We believe that requiring plans to offer flexibility on billing timing and multiple means of payment will facilitate beneficiary participation in the program and reduce the likelihood of missed payments.

AKF supports CMS's requirement that plans provide robust information within the billing statement. Particularly, we strongly support the requirement that plans include information on applying and enrolling in the Part D Low-Income Subsidy (LIS) program, and explaining that for those who qualify, enrolling in the LIS program is more advantageous than participation in the Medicare Prescription Payment Plan alone.

In addition to the required information in the billing statement that CMS lists in the draft guidance, we recommend that plans should also be required to provide information on the State Health Insurance Assistance Program (SHIP) as a resource for impartial information on Medicare programs. We also recommend billing statements contain clear explanations on the importance of avoiding late or missed payments, as well as clear language that a beneficiary will not pay more than $2,000 in OOP costs in a plan year and informing them when they have reached that cap and what their remaining payments will be for the year.

Finally, we appreciate CMS's clarification in the guidance that Medicare Prescription Payment Plan participants are protected from actions to collect unpaid debt related to the program.

Enrollee Outreach

The targeted enrollee outreach requirements will be an important tool to inform beneficiaries who may benefit from the Medicare Prescription Payment Plan about the program, and will be a critical part of an effective outreach strategy. However, we have concerns that using specific dollar amount thresholds that trigger targeted notifications may reduce information and outreach to beneficiaries who may benefit from the program. We suggest CMS reconsider a targeted outreach approach that uses specific dollar amount thresholds, or alternatively, set the threshold as low as possible.

We look forward to the opportunity to comment on the draft part two guidance, which will contain more information on enrollee outreach and education. As that guidance is developed, we urge CMS to include information on the Medicare Prescription Payment Plan in the Medicare Plan Finder tool, as well as the Medicare & You handbook and the Medicare website. Additionally, we urge CMS make available by fall 2024 a monthly cost calculator that lets beneficiaries know what their monthly payment obligations would be if they opt-in to the program, and to make this calculator available at each possible decision point.

Enrollee Election

We urge CMS to require plans and pharmacies to offer point-of-sale (POS) program election for beneficiaries by 2025. To avoid the impact of wait times on beneficiaries, CMS should not wait until 2026 or later to implement POS real-time or near-real-time election. POS election is a critical component for beneficiary participation and to minimize beneficiary burden. We and other patient organizations are committed to working with CMS and other stakeholders to ensure POS election is available by 2025.

Grace Periods and Notice Requirements

We recommend CMS implement a 3-month grace period for late payments, instead of the 2-month grace period in the draft guidance. We also recommend CMS clarify that the grace period carries over into the next calendar year if non-payment occurs at the end of a calendar year.

Thank you for the opportunity to provide comments on this draft guidance.

Sincerely,

Holly Bode
Vice President of Government Affairs