

DEPARTMENT OF HEALTH & HUMAN
SERVICES

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CENTER FOR MEDICARE

DATE: December 20, 2024

TO: All Part D Sponsors

FROM: Jennifer R. Shapiro, Director, Medicare Plan Payment Group

SUBJECT: Reminders Related to the Medicare Prescription Payment Plan

The purpose of this memorandum is to provide reminders to Part D plan sponsors and other interested parties about the Medicare Prescription Payment Plan, in advance of its implementation on January 1, 2025. CMS is also providing a technical correction to an example included in the Health Plan Management System (HPMS) memo “Technical Memorandum on the Changes to True Out-of-Pocket (TrOOP) Costs and the Calculation of the Maximum Monthly Cap for the Medicare Prescription Payment Plan,” published on April 25, 2024.

Beginning in CY 2025, Part D plan sponsors are required to provide all Part D enrollees with the option to pay their out-of-pocket (OOP) prescription drug costs in monthly amounts over the course of the plan year instead of paying OOP costs at the point of sale (POS). CMS issued the final part one guidance for the Medicare Prescription Payment Plan on February 29, 2024, and the final part two guidance for the Medicare Prescription Payment Plan on July 16, 2024.¹ On September 13, 2024, CMS issued the HPMS memo “Reporting Routing Values for the Medicare Prescription Payment Plan” to provide instructions to Part D sponsors for populating routing identifier values within HPMS for the Medicare Prescription Payment Plan.² CMS also issued an HPMS memo addressing “Frequently Asked Questions related to the Medicare Prescription Payment Plan” on October 1, 2024.

Beneficiary-Level Data Reporting

To effectively monitor the program, as stated in section 100 of the final part one guidance and described in the Information Collection Request (ICR) package “MARx Medicare Prescription

¹ Medicare Prescription Payment Plan guidance documents and other resources are available at: <https://www.cms.gov/inflation-reduction-act-and-medicare/part-d-improvements/medicare-prescription-payment-plan>.

² Previously published HPMS memoranda can be accessed at <https://www.cms.gov/about-cms/information-systems/hpms/hpms-memos-archive-weekly>

Payment Plan Beneficiary-Level Data Elements” (OMB control number 0938-1468), Part D plan sponsors are required to submit beneficiary-level data related to program participation through the Medicare Advantage Prescription Drug (MARx) System beginning January 1, 2025. Specifically, Part D plan sponsors are required to submit beneficiary-level data elements into the MARx system via a MARx Batch Input Transaction Data File. There is no limit to how often or how many Medicare Prescription Payment Plan batch input transactions Part D plan sponsors can make, and we encourage daily submissions of the data. For 2025, CMS will not require independent data validation for these new reporting requirements. CMS released detailed information related to the implementation of Medicare Prescription Payment Plan data collection in the October 7, 2024, HPMS memo *Announcement of the MARx Software Release*.

For questions related to the MARx software release, please contact the help desk directly at MAPDHelpDesk@cms.hhs.gov.

Application of Program Requirements to \$0 Cost Sharing Plans

As noted in the final part two guidance, requirements related to the Medicare Prescription Payment Plan apply to all Part D sponsors, including both stand-alone Medicare prescription drug plans (PDPs) and Medicare Advantage (MA) plans with prescription drug coverage (MA-PDs), as well as Employer Group Waiver Plans (EGWPs), cost plans, and demonstration plans. However, CMS understands that the Medicare Prescription Payment Plan has no practical application for enrollees in plans that exclusively charge \$0 cost sharing for covered Part D drugs. CMS does not expect Part D plans that exclusively charge \$0 cost sharing for covered Part D drugs to all plan enrollees to offer enrollees the option to pay their OOP costs through monthly payments over the course of the plan year or otherwise comply with the final part one guidance or final part two guidance.³

Enrollees in such plans do not incur any cost sharing for covered Part D drugs and, as a result, there are no OOP Part D drug costs that could be paid through monthly payments over the course of the plan year. Therefore, opting into the Medicare Prescription Payment Plan would have no practical benefit or effect for an enrollee of such a plan. The provision of information about the Medicare Prescription Payment Plan in plan promotional and educational materials could cause confusion among enrollees of such plans by informing them of a program that has no practical benefit or effect. Part D sponsors are encouraged to provide support tailored to the potential participant’s unique situation and clearly communicate to enrollees when it appears there is no practical benefit to program participation (e.g., enrollees with \$0 cost sharing for covered Part D drugs).

Interactions Between Low-Income Subsidy (LIS) and the Medicare Prescription Payment Plan

CMS reminds Part D plan sponsors that although LIS enrollees must have the option to become Medicare Prescription Payment Plan participants, individuals with low, stable drug costs (such as LIS enrollees) are not likely to benefit from the program, as noted in section 70.2 of the final part one guidance. Further, LIS enrollment, for those who qualify, is more advantageous than

³ We remind Part D plan sponsors that if the plan has any enrollees that could pay any cost sharing, even a nominal amount, under the Part D plan at any point during the year, then this clarification would not be applicable.

participation in the Medicare Prescription Payment Plan. There may be limited circumstances in which an LIS enrollee would benefit from remaining in the Medicare Prescription Payment Plan, such as when a participant incurs high OOP costs early in the year, and later becomes LIS-eligible with an effective date that is not retroactive to include the high-cost drugs. However, in general, participation in the Medicare Prescription Payment Plan is unlikely to benefit LIS enrollees. For potential Medicare Prescription Payment Plan participants who are already enrolled in the LIS program, Part D sponsors are encouraged to provide support tailored to their unique situation and clearly communicate to enrollees when it appears that they are less likely to benefit from the program (e.g., enrollees with low-to-moderate recurring OOP drug costs).

In order to promote awareness of the LIS program for enrollees potentially LIS-eligible and not yet enrolled, CMS has established requirements for Part D sponsors to provide information on the LIS program as part of their Medicare Prescription Payment Plan materials. As stated in section 30.3.1 of the final part two guidance, Part D sponsors must provide general information about applying for the LIS program and how to enroll (as an additional or alternative avenue for addressing prescription drug costs) in communications about the program with current and prospective program participants, noting that LIS enrollment, for those who qualify, is more advantageous than participation in the Medicare Prescription Payment Plan. In addition, section 40 of the final part one guidance and section 30.1 of the final part two guidance contain requirements for Part D plan sponsors to include general information about the LIS program on Medicare Prescription Payment Plan billing statements and on their websites, which must also note that LIS enrollment, for those who qualify, is likely to be more advantageous than participation in the Medicare Prescription Payment Plan.

Reporting Routing Values

As stated in the final part one guidance, to ensure a uniform, consistent claims adjudication process and to leverage existing Part D processes to minimize operational burdens, Part D plan sponsors and pharmacies must use a Bank Identification Number (BIN) and Processor Control Number (PCN) electronic claims processing methodology for applicable Medicare Prescription Payment Plan transactions. CMS provided instructions to Part D plan sponsors for populating routing identifier values within HPMS for the Medicare Prescription Payment Plan in the September 13, 2024, HPMS memo *Reporting Routing Values for the Medicare Prescription Payment Plan*. Part D plan sponsors must provide a Medicare Prescription Payment Plan-specific BIN/PCN and any other pertinent billing information to the pharmacy on paid claim responses when the enrollee is also a Medicare Prescription Payment Plan participant.

The functionality to report the Medicare Prescription Payment Plan-specific BIN/PCN is operational in HPMS. The final part one guidance requires that Part D plan sponsors assign a program-specific PCN that starts with “MPPP,” and the September 2024 HPMS memo established a deadline of October 15, 2024 to report the new BIN/PCN to CMS. In November 2024, CMS extracted and posted the information on the CMS website to assist those involved in the processing of pharmacy claims for Part D enrollees who have opted into the Medicare Prescription Payment Plan. A revised file was posted in December 2024. The BIN/PCN quarterly extract can be found on the Part D Information for Pharmaceutical Manufacturers page at the following website: <https://www.cms.gov/medicare/coverage/prescription-drug-coverage/part-d-information-pharmaceutical-manufacturers>.

This memo serves as a reminder to plans to follow the directions outlined in the September 2024 HPMS memo to report their Medicare Prescription Payment Plan-specific BIN/PCN. Plans that have not yet reported their Medicare Prescription Payment Plan BIN/PCN in HPMS should do so promptly. Plans that have reported a program-specific PCN starting with anything other than “MPPP” should revise the PCN to align with the requirements in the final part one guidance.

For questions regarding HPMS functionality, please contact the HPMS Help Desk at either 1800-220-2028 or hpms@cms.hhs.gov.

Correction to HPMS Memo

On April 25, 2024, CMS released an HPMS memo, “Technical Memorandum on the Changes to True Out-of-Pocket (TrOOP) Costs and the Calculation of the Maximum Monthly Cap for the Medicare Prescription Payment Plan,” which provided additional examples of program calculations for the Medicare Prescription Payment Plan. The table accompanying Example #2 in that memo incorrectly included OOP costs incurred for the month of June, when the example participant would have already reached the \$2,000 annual OOP threshold. A revised memo has been posted on the Medicare Prescription Payment Plan resource website.⁴

Please direct any other questions regarding the information included in this memo to MedicarePrescriptionPaymentPlan@cms.hhs.gov.

⁴ <https://www.cms.gov/inflation-reduction-act-and-medicare/part-d-improvements/medicare-prescription-paymentplan>