

DEPARTMENT OF HEALTH & HUMAN SERVICES  
Centers for Medicare & Medicaid Services  
7500 Security Boulevard  
Baltimore, Maryland 21244-1850



**CENTER FOR MEDICARE**

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**DATE:** August 21, 2023

**TO:** Interested Parties

**FROM:** Meena Seshamani, M.D., Ph.D., CMS Deputy Administrator and Director of the Center for Medicare

**SUBJECT:** 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

**10. Introduction**

The purpose of this document is to provide interested parties with draft part one guidance on a select set of topics for the *Maximum Monthly Cap on Cost-Sharing Payments Program*, which was established by section 11202 of the Inflation Reduction Act (IRA) (P.L. 117-169) and signed into law on August 16, 2022. The IRA makes Medicare stronger for current and future enrollees. It makes health care more accessible, equitable, and affordable. Section 1860D-2(b)(2)(E) of the Social Security Act (the Act), as added by section 11202 of the IRA, requires all Medicare prescription drug plans to offer their Part D enrollees the option to pay their out-of-pocket (OOP) Part D drug costs through monthly payments over the course of the plan year instead of as upfront payments at the pharmacy point of sale (POS) beginning January 1, 2025. This provision applies to all Part D sponsors,<sup>1, 2</sup> 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. This guidance document will be followed by a second round of guidance, set to be released by early 2024.

The Maximum Monthly Cap on Cost-Sharing Payments Program was sometimes previously referred to as “the OOP Smoothing Program.” CMS undertook beneficiary focus group testing to select a program name that would be meaningful to Medicare Part D enrollees. After multiple rounds of consumer testing fieldwork and evaluation of the results, CMS is announcing that the

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<sup>1</sup> This provision does not apply to the Limited Income Newly Eligible Transition (LI NET) coverage because participants in the LI NET program do not enroll in a PDP or MA-PD plan to receive transitional coverage under the program.

<sup>2</sup> Under section 1894(a) of the Act, PACE organizations must provide all medically necessary services including prescription drugs, without application of deductibles, copayments, coinsurance, or other cost sharing that would otherwise apply under Medicare or Medicaid. While the Medicare Prescription Payment Plan is applicable to all Part D plans, it has no practical application for PACE organizations. In addition, the program has no application to those demonstration Medicare-Medicaid Plans (MMPs) that have no Part D cost sharing.

shorthand name for the program will be the “Medicare Prescription Payment Plan.” Henceforth, this document refers to the Maximum Monthly Cap on Cost-Sharing Payments Program established by section 11202 of the IRA as the Medicare Prescription Payment Plan, or the program as needed. Medicare Prescription Payment Plan should be used in any guidance and communications by Part D sponsors for the implementation of section 1860D-2(b)(2)(E).

In the technical HPMS guidance titled “Technical Memorandum on the Calculation of the Maximum Monthly Cap on Cost-Sharing Payments Under Prescription Drug Plans” issued on July 17, 2023, CMS used the term “enrollee” when referring to someone using the OOP cost sharing payment options in the Medicare Prescription Payment Plan. In this guidance, CMS is replacing that term with the term “program participant,” or “participant,” for short. Medicare Prescription Payment Plan participants can voluntarily opt into the program at the time they enroll in a Part D plan or later throughout the plan year, and such an election will not have any bearing on their Part D plan enrollment. This change of terminology is important for Part D enrollees to keep the concept of their Part D plan enrollment distinct from their participation in the Medicare Prescription Payment Plan. CMS urges all Part D sponsors to be mindful of the language used when referring to Medicare Prescription Payment Plan participants so as not to cause confusion or alarm if, for instance, a Part D enrollee is informed that their participation in the Medicare Prescription Payment Plan has been terminated. In addition, the preferred terminology for an individual choosing to participate in the Medicare Prescription Payment Plan is “opt in,” but there may be instances in which the term “elect” into the program is acceptable. CMS discourages use of the term “enroll” when referring to an individual opting into or participating in the Medicare Prescription Payment Plan.

Section 11202(c) of the IRA directs the Secretary to implement the Medicare Prescription Payment Plan for 2025 by program instruction or other forms of program guidance. In accordance with the law, CMS is issuing this draft guidance for implementation of the Medicare Prescription Payment Plan for 2025. This draft guidance builds on the July 17, 2023, HPMS memo titled “Technical Memorandum on the Calculation of the Maximum Monthly Cap on Cost-Sharing Payments Under Prescription Drug Plans” and proposes requirements related to an initial set of topics pertaining to the implementation of the Medicare Prescription Payment Plan for 2025 (January 1, 2025, to December 31, 2025), specifying requirements that will be applicable to Part D sponsors.

CMS is voluntarily soliciting comment on this draft guidance. Please send comments pertaining to this draft guidance to [PartDPaymentPolicy@cms.hhs.gov](mailto:PartDPaymentPolicy@cms.hhs.gov) with the subject line “Medicare Prescription Payment Plan Guidance.” Comments received by September 20, 2023, will be considered. CMS will issue final guidance for 2025 after considering the public comments received in response to this draft guidance. In final guidance, CMS may make changes to any policies, including policies on which CMS has not expressly solicited comment, based on the agency’s further consideration of the relevant issues. This guidance is for the first year of the program, and the policies established in the final guidance will be subject to change in subsequent years.

If any provision in this guidance is held to be invalid or unenforceable, it shall be severable from the remainder of this guidance, and shall not affect the remainder thereof, or the application of the provision to other persons or circumstances.

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Again, this draft part one guidance addresses the topics listed above, which represent a subset of topics which CMS will address via program instruction or other forms of program guidance in order to implement the Medicare Prescription Payment Plan for 2025. This draft part one guidance will be finalized by spring 2024 after consideration of all comments received on the draft. CMS will issue a draft part two guidance, as well as model language and supporting materials, covering additional topics, such as outreach and education, by early 2024. CMS will follow the same procedures for comment solicitation before finalizing the additional guidance in spring or early summer 2024.

## 20. Overview

Beginning in 2025, the statute requires Part D sponsors to provide all Part D enrollees the option to pay their OOP prescription drug costs in monthly installments over the course of the plan year, instead of paying OOP costs at the POS. As a result, Part D enrollees who opt into the Medicare Prescription Payment Plan will pay \$0 at the POS for a covered Part D drug, instead of the OOP cost sharing they would normally pay when filling a prescription. The Part D sponsor must pay the pharmacy the OOP cost sharing amount that these participants would have paid if they were not in the Medicare Prescription Payment Plan and then bill the program participants monthly for any OOP cost sharing they incurred while in the program according to the calculations described below. The amount that the Part D sponsor bills the participant for a month under the program cannot exceed a maximum monthly cap. While this program is available to anyone with Medicare Part D drug costs, Part D enrollees incurring high OOP costs earlier in the plan year are generally likely to benefit. CMS will develop tools (e.g., model documents and training materials) to help Part D enrollees decide whether the program is right for them. CMS welcomes

input from interested parties on the kinds of tools and decision supports that will be most helpful to Part D enrollees making this choice.

Under section 1860D–2(b)(2)(E) of the Act, as added by section 11202 of the IRA, Part D sponsors must, among other requirements:

- (1) provide all Part D enrollees prior to and during the plan year with the option to elect into the Medicare Prescription Payment Plan to pay their OOP cost sharing in monthly amounts that are spread throughout the plan year according to a statutory formula;
- (2) determine a maximum monthly cap for each month's amount;
- (3) bill the program participant for an amount that must not exceed the monthly cap applicable for a month; and
- (4) have in place a mechanism to notify a pharmacy during the plan year when a Part D enrollee incurs OOP costs with respect to covered Part D drugs that make it likely the Part D enrollee may benefit from the program.

To allow for public input, CMS is voluntarily soliciting comments on all sections of this draft guidance, and specifically on certain topics related to the Medicare Prescription Payment Plan, including:

- Participant billing requirements (section 40);
- Pharmacy payment obligations and claims processing (section 50);
- Requirements related to Part D enrollee outreach (section 60);
- Requirements related to Part D enrollee election, including a request for information on real-time POS election (section 70);
- Procedures for termination of election, reinstatement, and preclusion (section 80);
- Participant disputes (section 90); and
- Data submission requirements (section 100).

In addition, to help inform the development of draft part two guidance, CMS requests feedback on the best ways to educate Part D enrollees about the program. Specifically, CMS seeks input on:

- Which model documents or other materials would be helpful to update and develop for interested parties;
- Ways to most effectively conduct outreach and education to interested parties about the program;
- How to leverage existing resources and information, including the State Health Insurance Assistance Program (SHIP); and
- How to communicate about overlapping programs (e.g., LIS and Medicare Savings Programs).

### 30. Program Calculations and Examples<sup>3</sup>

Section 1860D–2(b)(2)(E)(iv) of the Act specifies how the monthly caps on OOP cost sharing payments are to be calculated. The formula for calculating the cap differs for the first month of participation in the program, versus the remaining months of the year. The maximum monthly cap calculations include specifics of a participant’s Part D drug costs (previously incurred costs and new OOP costs), as well as the number of months remaining in the plan year; as such, the amount can vary from person-to-person and month-to-month. Assuming a program participant remains in the Medicare Prescription Payment Plan through the end of the plan year, the total amounts billed monthly through the December payment (which would be billed and paid in the following year) will equal the total OOP costs incurred by the participant under this program during the year.

The participant will not have any monthly bills to pay under this program until opting into the program and incurring OOP costs. Once a participant incurs an OOP Part D drug cost, all their OOP costs for all covered Part D drugs will be billed on a monthly basis as long as the participant remains in the program. Program calculations apply to all OOP Part D costs incurred, including those in the deductible phase. Part D sponsors must include all covered Part D drugs in the program. However, non-covered drugs are excluded.<sup>4</sup> Part D sponsors will be responsible for correctly calculating the monthly caps based on the statutory formulas, determining the amount to be billed (not to exceed the cap), and sending monthly bills to program participants.

Opting into the program will not impact how a program participant moves through the Part D benefit or what counts towards their true out-of-pocket (TrOOP) costs. Under section 1860D–2(b)(4)(F) of the Act, a participant’s TrOOP-eligible costs under the Medicare Prescription Payment Plan will still be treated as incurred based on the date each Part D claim is adjudicated. Opting into the program only provides participants with the ability to spread OOP costs over the year – the total incurred costs and the timing of TrOOP accumulation do not change.

For participants who fill prescriptions for an extended day supply, their OOP costs for those prescriptions will be attributed to the month the prescription was filled, not pro-rated over the months covered by the prescription. For example, if a participant in the program has \$300 in OOP costs incurred for a 90-day supply dispensed in January, the full \$300 will be counted as incurred in January.

The example calculations presented below are illustrative and intended to help ensure Part D sponsors program their claims and billing systems correctly for 2025. For more general audiences, CMS will develop tools to help people with Medicare Part D and their caregivers learn what monthly payments might look like under this program. CMS welcomes input from interested parties on the kinds of tools that will be most helpful.

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<sup>3</sup> The information in this section is consistent with what CMS published in the “Technical Memorandum on the Calculation of the Maximum Monthly Cap on Cost-Sharing Payments Under Prescription Drug Plans” on July 17, 2023. CMS has included additional detail in this document.

<sup>4</sup> Covered Part D drugs has the meaning set forth at 42 CFR § 423.100.

### 30.1 Calculation of Maximum Monthly Cap in First Month

Under section 1860D–2(b)(2)(E)(iv)(I) of the Act, for the first month for which the Part D enrollee has opted into the Medicare Prescription Payment Plan, the term “maximum monthly cap” means an amount determined by calculating the annual OOP threshold minus any Part D costs the Part D enrollee incurred during the year before opting in, divided by the number of months remaining in the plan year.

Under section 1860D-2(b)(4)(B)(i)(VII), the annual OOP cost threshold for 2025 is \$2,000. “Incurred costs” means any costs incurred or treated as incurred under section 1860D-2(b)(4)(C). When an individual opts into the Medicare Prescription Payment Plan during the plan year, the individual’s incurred costs used to calculate the first month maximum cap are equal to the individual’s accumulated TrOOP before opting into the program. The number of months remaining in the plan year includes the month when an individual opts into the program.

When an individual opts into the Medicare Prescription Payment Plan prior to the start of the plan year (such as during open enrollment), the first month maximum monthly cap calculation applies to their first month of active coverage within the plan year. In this instance, the number of months remaining in the plan year is 12 and there is no accumulated TrOOP to subtract from the OOP threshold.

In scenarios where the OOP costs incurred in the first month of participation in the program are less than the maximum monthly cap, a Part D sponsor cannot bill the participant more than their actual incurred OOP costs. Specifically, a Part D sponsor must bill the participant the lesser of the participant’s actual OOP costs or the first month’s maximum monthly cap.

*First Month Maximum Cap =*

$$\frac{\text{Annual OOP Threshold} - \text{Incurred Costs of the Participant}}{\text{Number of Months Remaining in the Plan Year}}$$

### 30.2 Calculation of Maximum Monthly Cap in Subsequent Months

Under section 1860D–2(b)(2)(E)(iv)(II) of the Act, for each subsequent month for which the Part D enrollee has opted into the program, the maximum monthly cap is determined by calculating the sum of any remaining OOP costs owed by the participant from a previous month that have not yet been billed and any additional OOP costs incurred by the participant in the subsequent month, divided by the number of months remaining in the plan year.<sup>5</sup> The number of months remaining includes the month for which the cap is being calculated. This calculation repeats for each month in which the participant remains in the Medicare Prescription Payment Plan. The resulting maximum monthly cap will change if additional OOP costs are incurred.

Note that “OOP costs incurred by the participant” refers only to the patient pay portion for covered Part D drugs that a program participant would have paid at the POS if they had not opted

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<sup>5</sup> The maximum monthly cap calculation in subsequent months applies to newly incurred OOP costs and previous costs not yet billed. If there are unpaid amounts from prior monthly bills, the total billed amount may be higher than the maximum monthly cap.

into the Medicare Prescription Payment Plan, not to all incurred costs as defined under section 1860D–2(b)(4)(C) of the Act. For these calculations, the “OOP costs incurred by the participant” do not include the covered plan paid amount or amounts paid by third parties, such as qualified State Pharmaceutical Assistance Programs (SPAPs) or charities.

$$\text{Subsequent Month Maximum Cap} = \frac{\text{Sum of Remaining OOP Costs Not Yet Billed to Participant} + \text{Additional OOP Costs Incurred by the Participant}}{\text{Number of Months Remaining in the Plan Year}}$$

### 30.3 Example Calculations<sup>6</sup>

Additional example calculations can be found in Appendix B.

#### 30.3.1 *Example #1: January Election; First Fill in February with No Refills*

Calculation of Maximum Monthly Cap in First Month: This example demonstrates how the maximum monthly cap would be calculated for a participant with no prescriptions filled in the first month of their participation in the program. The individual opts into the Medicare Prescription Payment Plan in January 2025. They have no additional prescription drug coverage through a third party. They fill no prescriptions during January.

Step 1: Determine the previously incurred costs. The participant has had no prior pharmacy expenditures in January 2025; the TrOOP Accumulator is \$0.

Step 2: Calculate the maximum monthly cap for the first month in which the program is effective for the participant. The annual OOP threshold for 2025 is \$2,000. The month is January; months remaining in the plan year equals 12 (includes January).

$$(\$2,000 - \$0)/12 = \$166.67$$

The plan will not bill the participant for January, since the participant has not incurred any OOP costs.

Calculation of Maximum Monthly Cap in Subsequent Months: The participant fills a high-cost prescription at the pharmacy in February. The OOP cost sharing for this prescription is \$1,030.37.

Step 1: Determine the remaining costs owed by the participant. The participant incurred \$0 in January and thus did not receive a bill.

$$\$0 - \$0 = \$0$$

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<sup>6</sup> Normal rounding rules have been applied to the maximum monthly cap calculations.

Step 2: Determine the additional OOP costs incurred by the participant. The participant fills a single prescription with an OOP cost of \$1,030.37. Additional OOP costs incurred = \$1,030.37.

Step 3: Calculate the maximum monthly cap for the subsequent month. The month is February; months remaining in the plan year equals 11 (includes February).

$$(\$1,030.37 + \$0)/11 = \$93.67$$

The calculation for the maximum monthly cap in subsequent months, described above, is repeated for each month remaining in the plan year and will change if there are additional OOP costs incurred by the participant. If the participant in Example #1 continued to have no new covered Part D prescription drug costs, their maximum monthly cap would be \$93.67 for all the months remaining in the plan year, as shown below.

Month	OOP Costs Incurred	Maximum Monthly Cap	Monthly Participant Payment
January	\$0	\$166.67	\$0
February	\$1,030.37	\$93.67	\$93.67
March	\$0	\$93.67	\$93.67
April	\$0	\$93.67	\$93.67
May	\$0	\$93.67	\$93.67
June	\$0	\$93.67	\$93.67
July	\$0	\$93.67	\$93.67
August	\$0	\$93.67	\$93.67
September	\$0	\$93.67	\$93.67
October	\$0	\$93.67	\$93.67
November	\$0	\$93.67	\$93.67
December	\$0	\$93.67	\$93.67
<b>TOTAL</b>	<b>\$1,030.37</b>		<b>\$1,030.37</b>

### 30.3.2 Example #2: Open Enrollment Election with Low-Cost Drugs in January

Calculation of Maximum Monthly Cap in First Month: This example demonstrates how the maximum monthly cap would be calculated for a participant with a single low-cost drug filled in January. The individual opts into the Medicare Prescription Payment Plan during Medicare Part D open enrollment, based on their existing prescription for a high-cost maintenance drug. This participant has no additional prescription drug coverage through a third party. This participant has enough of their high-cost drug on hand for the month of January and only fills a low-cost drug during this month. The OOP cost sharing for this prescription is \$4.00.

Step 1: Determine the previously incurred costs. The participant has had no prior pharmacy expenditures in January 2025; the TrOOP Accumulator is \$0.

Step 2: Calculate the maximum monthly cap for the first month in which the program is effective for the participant. The annual OOP threshold for 2025 is \$2,000. The month is January; months remaining in the plan year equals 12 (includes January).

$$(\$2,000 - \$0)/12 = \$166.67$$

The plan will bill \$4 for January, since the OOP incurred amount is lower than the cap.

*Note:* when the amount incurred in the first month in the program is less than the maximum monthly cap, the participant cannot be billed more than their actual OOP costs in that month. Therefore, the participant would be billed \$4.00 for January.

Calculation of Maximum Monthly Cap in Subsequent Months: The participant does not need to refill their low-cost prescription filled in January but refills their high-cost maintenance drug in February.

Step 1: Determine the remaining costs owed by the participant. The participant incurred \$4.00 in January and was billed \$4.00.

$$\$4.00 - \$4.00 = \$0$$

Step 2: Determine the additional OOP costs incurred by the participant. The participant refills a high-cost prescription in February that causes them to reach the annual OOP threshold. Part D cost sharing for this drug is \$2,534.11, but the final OOP cost sharing would be \$1,996.00 (capped by the OOP threshold of \$2,000; \$2,000 - \$4.00 = \$1,996.00). Additional OOP costs incurred = \$1,996.00.

Step 3: Calculate the maximum monthly cap for the subsequent month. The month is February; months remaining in the plan year equals 11 (includes February). (*Note that \$0 is added to the \$1,996 because the participant was billed and paid in full the \$4 that was due for January*).

$$(\$0 + \$1,996.00)/11 = \$181.45$$

Because the participant in Example #2 has already met the annual OOP threshold, they will incur no new additional OOP costs. Their maximum monthly cap would be approximately \$181.45 for all months remaining in the plan year, as shown below.

<b>Month</b>	<b>OOP Costs Incurred</b>	<b>Maximum Monthly Cap</b>	<b>Monthly Participant Payment</b>
January	\$4.00	\$166.67	\$4.00
February	\$1,996.00	\$181.45	\$181.45
March	\$0	\$181.46	\$181.46
April	\$0	\$181.45	\$181.45
May	\$0	\$181.46	\$181.46
June	\$0	\$181.45	\$181.45

Month	OOP Costs Incurred	Maximum Monthly Cap	Monthly Participant Payment
July	\$0	\$181.46	\$181.46
August	\$0	\$181.45	\$181.45
September	\$0	\$181.46	\$181.46
October	\$0	\$181.45	\$181.45
November	\$0	\$181.46	\$181.46
December	\$0	\$181.45	\$181.45
<b>TOTAL</b>	<b>\$2,000.00</b>		<b>\$2,000.00</b>

### 30.3.3 Example #3: April Election with 90-Day Supply of a Drug with Remaining Deductible

Calculation of Maximum Monthly Cap in First Month: The example demonstrates how the maximum monthly cap would be calculated for an individual who opts into the Medicare Prescription Payment Plan in April and fills a prescription for a 90-day supply. They have no additional prescription drug coverage through a third party. In April 2025, after opting into the program, the participant fills a new prescription for a 90-day supply. Prior to April, the participant has filled low-cost monthly maintenance drugs, so they have not yet reached their deductible. The total OOP cost sharing for the prescription in April, including the remainder of the \$545 deductible, is \$617.00.<sup>7</sup>

Step 1: Determine the previously incurred costs. The participant has filled multiple, low-cost generic drugs from January through March 2025; the TrOOP Accumulator is \$12.00.

Step 2: Calculate the maximum monthly cap for the first month in which the Medicare Prescription Payment Plan is effective for the participant. The annual OOP threshold for 2025 is \$2,000. The month is April; months remaining in the plan year equals 9 (includes April).

$$(\$2,000 - \$12.00)/9 = \$220.89$$

The plan will bill \$220.89 for April, since the OOP incurred amount of \$617.00 is higher than the maximum monthly cap.

Calculation of Maximum Monthly Cap in Subsequent Months: In May 2025, the participant refills only their existing generic maintenance drug (OOP cost sharing: \$4.00).

Step 1: Determine the remaining costs owed by the participant. The participant incurred \$617.00 in April and was billed \$220.89.

$$\$617.00 - \$220.89 = \$396.11$$

<sup>7</sup> \$545 deductible is based on 2024 Part D benefit parameters; amounts subject to change with updated Part D benefit parameters for 2025.

Step 2: Determine the additional OOP costs incurred by the participant. The participant refills only their generic maintenance drugs during this month. Additional OOP costs incurred = \$4.00.

Step 3: Calculate the maximum monthly cap for the subsequent month. The month is May; months remaining in the plan year equals 8 (includes May).

$$(\$396.11 + \$4.00)/8 = \$50.01$$

If the participant in Example #3 continued this pattern of 90-day fills (with a \$120 copay after meeting the deductible in April) and monthly generic fills (\$4 copay), their maximum monthly cap would update as shown below.

Month	OOP Costs Incurred	Maximum Monthly Cap	Monthly Participant Payment
January	\$4.00	N/A	\$4.00*
February	\$4.00	N/A	\$4.00*
March	\$4.00	N/A	\$4.00*
April	\$617.00	\$220.89	\$220.89
May	\$4.00	\$50.01	\$50.01
June	\$4.00	\$50.59	\$50.59
July	\$124.00	\$71.25	\$71.25
August	\$4.00	\$72.05	\$72.05
September	\$4.00	\$73.05	\$73.05
October	\$124.00	\$114.39	\$114.39
November	\$4.00	\$116.39	\$116.39
December	\$4.00	\$120.38	\$120.38
<b>TOTAL</b>	<b>\$901.00</b>		<b>\$901.00</b>

\*These payments were made directly to the pharmacy, outside of the Medicare Prescription Payment Plan.

#### 40. Participant Billing Requirements

Section 1860D-2(b)(2)(E)(iii) of the Act requires Part D sponsors to bill participants who are in the Medicare Prescription Payment Plan and incur OOP costs an amount for each month that cannot exceed the applicable maximum monthly cap. For each billing period after an individual has opted into the program and incurred OOP costs, the Part D sponsor will calculate a monthly amount that takes into account the OOP costs in that month that were incurred on or after the date on which the individual opted into the program. Each billing period will be a calendar month. A Part D sponsor must not bill a participant who is in the program but has not yet incurred any OOP costs during the plan year.

Note that past due balances from prior monthly bills may also be included in a billing statement, which could result in the total amount on the billing statement exceeding the maximum monthly cap. However, the amount billed *for the month for which the maximum monthly cap is being*

*calculated* cannot be higher than the cap for that month. For example, in example #3 in this guidance (section 30.3.3), the maximum monthly cap and monthly participant payment for the first month in the program (April) is \$220.89. The maximum monthly cap amount for May (the participant's second month in the program) is \$50.01. If the participant paid only \$200.00 of their first month's bill, the remaining \$20.89 ( $\$220.89 - \$200.00 = \$20.89$ ) could be added to the bill for May, as a separate line item from the May monthly participant payment (which would be capped by the maximum monthly cap calculation). The total billed amount for May would then be \$70.90 ( $\$50.01 + \$20.89 = \$70.90$ ).<sup>8</sup>

CMS encourages Part D sponsors to offer multiple means of payment, such as an electronic fund transfer mechanism (including automatic charges of an account at a financial institution or credit or debit card account) and payment by cash or check. We also encourage Part D sponsors to offer participants flexibility around requesting a specific day of the month for program charges and withdrawals from a bank account.

Because Part D sponsors (and any third parties Part D sponsors contract with) may not bill a participant more than the maximum monthly cap, late fees, interest payments, or other fees, such as for different payment mechanisms, are not permitted under the program.

Regardless of whether they are provided by mail or electronically, billing statements must contain the following information:

- A statement that the bill is for the Medicare Prescription Payment Plan, a brief description of the program, and a reference to where additional information about the program can be found;
- The effective date of program participation;
- The last payment received, showing the date, amount of the last payment, and the means of payment made by the participant;
- Any balance carried over from the prior month, including any missed payments;
- Itemized OOP costs by prescription for the month being billed;
- The amount due from the participant for the month being billed (i.e., the amount based on the application of the monthly cap calculation);
- The remaining total OOP cost sharing balance;
- Information on the next steps if the participant fails to pay by the stated due date;
- Information on how to voluntarily opt out of the program and balances due if participation is terminated;
- Information on the dispute processes available if the individual disputes their bill;
- General information about applying for the LIS program and how to enroll (as an additional or alternative avenue for addressing prescription drug costs), noting that LIS enrollment, for those who qualify, is more advantageous than participation in the Medicare Prescription Payment Plan alone; and
- Plan contact information for participant questions about the billing statement.

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<sup>8</sup> The example outlined here assumes that the Part D sponsor has the necessary information to include the April unpaid amounts in the bill for May.

CMS reminds Part D sponsors that actions to collect unpaid debt related to the program may be subject to other applicable federal and state laws and requirements. Additionally, CMS is considering specific requirements related to debt collection for amounts due under the program and requests comment.

#### 40.1 Prioritization of Premium Payments

While Part D sponsors may create their own billing and payment procedures for the Medicare Prescription Payment Plan, CMS encourages Part D sponsors to prioritize payments towards Part D plan premiums to avoid a Part D enrollee losing their Part D coverage. Specifically, if a Part D enrollee has opted into the program and makes payments directly to the Part D sponsor and it is unclear whether a payment should go towards the participant's outstanding Part D plan premium or Medicare Prescription Payment Plan balance, CMS encourages Part D sponsors to work with the Part D enrollee to prioritize payments towards Part D plan premiums.

Note that the above billing requirements apply only to bills for amounts due under the Medicare Prescription Payment Plan. Part D sponsors must send a separate bill for the collection of premiums, if applicable, and continue to follow existing regulations and guidance for the collection of premiums as described at 42 CFR § 423.293.

#### 40.2 Financial Reconciliation Process

Section 1860D–2(b)(2)(E)(v)(III)(gg) of the Act specifies that Part D sponsors must have a financial reconciliation process in place to correct inaccuracies in billing and/or payments.

While a Part D sponsor may not bill a program participant an amount for a month that is more than the maximum monthly cap, a participant may pay more than the maximum monthly cap up to the annual OOP threshold. However, the participant cannot pay more than their total OOP costs incurred.

Sponsors must continue to bill amounts owed under the program in monthly amounts not to exceed the maximum monthly cap according to the statutory formula for the duration of the plan year after an individual has been terminated, voluntarily or involuntarily. CMS requests comment on additional financial reconciliation standards that may be appropriate for the program.

### **50. Pharmacy Payment Obligations and Claims Processing**

Consistent with 1860D–2(b)(2)(E)(v)(III)(ff) of the Act, Part D sponsors must pay the pharmacy the enrollee's cost-sharing amount in addition to the Part D sponsor's portion of the payment. As program participants will pay \$0 at the POS instead of the OOP cost sharing they would normally pay at the POS when filling a prescription, Part D sponsors must pay the pharmacy the enrollee's cost-sharing amount in addition to the Part D sponsor's portion of the payment.

Consistent with section 1860D-12(b)(4) of the Act and 42 CFR § 423.520, Part D sponsors must reimburse a network pharmacy the total of a participant's OOP amount and the Part D sponsor

portion of the payment for a covered Part D drug no later than 14 days after the date on which the claim is received for an electronic claim or no later than 30 days after the date on which the claim is received for any other claim. The timing of payment of the total of a participant's OOP amount and the Part D sponsor portion of the payment for long-term care and home infusion pharmacies should follow current practices for payment of the Part D sponsor portion to be consistent with this requirement.

#### 50.1 Pharmacy Claims Processing Requirements

To ensure that an individual's participation in the Medicare Prescription Payment Plan has no effect on the amount paid to pharmacies in accordance with section 1860D-2(b)(2)(E)(v)(III)(ff) of the Act, the Part D sponsor must pay the pharmacy for the amount the individual would have otherwise paid at the POS. An individual's OOP costs are net of any contributions made by supplemental payers to Part D that the individual may be entitled to and that reduce the OOP amount due. CMS is aware that the current coordination of benefits (COB) electronic billing process may be disrupted if a Part D sponsor initially returns an amount of \$0 in the National Council for Prescription Drug Programs (NCPDP) telecommunications standard response pricing segment field "Patient Pay Amount" (505-F5) on a Part D claim because this amount may be used by supplemental payers to determine if additional benefits are provided. Additionally, this amount may be used by Part D sponsors for other downstream reporting requirements, such as prescription drug event (PDE) records and explanation of benefits (EOB) reporting, which reflect the actual participant liability amounts as incurred.

CMS is seeking feedback on a claims processing methodology to ensure a timely, uniform, and seamless implementation for all interested parties; provide a consistent participant experience; and minimize disruption to existing processes. At this time, CMS is encouraging the adoption of an electronic claims processing methodology such as the one currently used for real-time COB billing transactions using NCPDP standards. Part D sponsors would utilize an additional Bank Identification Number (BIN) and/or Processor Control Number (PCN) unique to the Medicare Prescription Payment Plan to facilitate electronic processing of supplemental COB transactions for program participants.

This method would result in two transactions being submitted to the same Part D sponsor but using two different BIN/PCN combinations. The Part D sponsor's primary unique BIN/PCN (as required by 42 CFR § 423.120(c)(4)) would be used for the initial Part D claim adjudication, while a second Medicare Prescription Payment Plan BIN/PCN would be used to process only the final participant liability amount; this process would account for any other payments made by supplemental coverage to which the participant may be entitled. This transaction processed through the Medicare Prescription Payment Plan BIN/PCN would be submitted last, in order to capture the final patient responsibility amount after all other payers have paid, so that the Part D sponsor could pay the pharmacy for the amount the participant would otherwise owe at the POS to obtain their prescription. To clarify, Medicare Prescription Payment Plan payments are not considered to be other health insurance (OHI), as the participant's Part D sponsor is the source of both primary and program payments. Information Reporting (N) transactions would not be generated for Medicare Prescription Payment Plan COB transactions, as the Part D plan is the entity processing the claim and would already be aware of necessary transaction data.

This system would allow Part D sponsors to continue to adhere to Medicare Secondary Payer (MSP) laws and any other federal and state laws establishing payers of last resort (e.g., AIDS Drug Assistance Programs (ADAPs)), as discussed in the Medicare Prescription Drug Benefit Manual Chapter 14, Section 30.3.<sup>9</sup> As noted above, payments made through the Medicare Prescription Payment Plan BIN/PCNs are to be processed after all other payers, including SPAPs or ADAPs.

Example of proposed electronic claims processing workflow:

1. Pharmacy submits billing transaction using Part D plan's primary BIN/PCN.
2. Pharmacy receives paid claim response reflecting Part D plan and participant responsibility amounts.
  - a. Pharmacy receives message on paid claim that individual is enrolled in the Medicare Prescription Payment Plan and is provided with the plan's Medicare Prescription Payment Plan BIN/PCN, along with any known OHI (if applicable).
3. Pharmacy submits COB transactions to known OHI (if applicable).
  - a. If Part D copay is already \$0, then COB transactions to OHI is not necessary.
4. Pharmacy submits final COB transaction to the plan's Medicare Prescription Payment Plan BIN/PCN reflecting final participant responsibility amount after all other payers have paid.
  - a. If participant responsibility has already been reduced to \$0 by OHI, then COB transaction to the plan's Medicare Prescription Payment Plan BIN/PCN is not necessary.
5. Pharmacy receives paid claim response reflecting \$0 participant responsibility.
  - a. The amount paid by the plan's Medicare Prescription Payment Plan BIN/PCN on this final COB transaction would be considered the OOP costs covered by the Part D sponsor to be used for billing purposes.

Example 1 with no OHI: \$100 negotiated price in Initial Coverage Phase of Defined Standard plan.

1. Pharmacy submits \$100 claim to Part D plan's primary BIN/PCN.
2. Pharmacy receives paid claim response reflecting \$25 Patient Pay Amount and \$75 Total Amount Paid.
  - a. Pharmacy receives paid claim response message that the individual has opted into the Medicare Prescription Payment Plan and is provided with the plan's Medicare Prescription Payment Plan BIN/PCN to bill the final participant responsibility amount as a COB transaction.
3. Pharmacy submits COB transaction for \$25 to the plan's Medicare Prescription Payment Plan BIN/PCN.
4. Pharmacy receives paid claim response on COB transaction reflecting \$0 Patient Pay Amount and \$25 Total Amount Paid.

Example 2 with OHI: \$100 negotiated price in Initial Coverage Phase of Defined Standard plan.

1. Pharmacy submits \$100 claim to Part D plan's primary BIN/PCN.
2. Pharmacy receives paid claim response reflecting \$25 Patient Pay Amount and \$75 Total Amount Paid.

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<sup>9</sup> Refer to Medicare Prescription Drug Benefit Manual; [Chapter 14 – Coordination of Benefits](#).

- a. Pharmacy receives paid claim response message that the individual has opted into the Medicare Prescription Payment Plan and is provided with the plan's Medicare Prescription Payment Plan BIN/PCN to bill the final participant responsibility amount as a COB transaction, along with data for another supplemental payer to Part D.
3. Pharmacy submits COB transaction to other supplemental payer (OHI).
4. Pharmacy receives paid claim response on COB transaction to OHI reflecting \$5 Patient Pay Amount and \$20 Total Amount Paid.
5. Pharmacy submits COB transaction for \$5 to the plan's Medicare Prescription Payment Plan BIN/PCN.
6. Pharmacy receives paid claim response on COB transaction reflecting \$0 Patient Pay Amount and \$5 Total Amount Paid.

CMS believes this approach would work in conjunction with existing COB processes while providing Part D sponsors the opportunity to evaluate the accuracy of the Medicare Prescription Payment Plan amount they are to pay the pharmacy on behalf of the participant.

CMS is aware of another method proposed by interested parties using a Part D sponsor-issued pre-funded payment card (similar to a Health Savings Account (HSA) card) that the Medicare Prescription Payment Plan participant would present at the pharmacy to pay for their liability amount owed at the POS. This method would keep the pharmacy whole and could allow for COB with other payers supplemental to Part D. However, CMS is concerned this approach does not provide the same level of Part D sponsor oversight to ensure that payments are only made for covered Part D drugs for the participant cardholder. Additionally, there are other concerns surrounding timeliness of issuing payment cards and participants needing to present a physical card at the POS, which could be forgotten, lost, or stolen, potentially causing delays in obtaining prescription drugs, elevated risk of fraud, and additional costs to the Part D program. CMS is also aware that not all organizations have the financial capabilities established to enable a pre-funded payment card system. Moreover, interested parties have also expressed a desire to have a single, uniform method of adjudicating and managing the patient liability for the Medicare Prescription Payment Plan at the POS.

CMS encourages interested parties to evaluate and provide comment on other claims processing options that will satisfy the statutory provisions of the Medicare Prescription Payment Plan while having minimal effect on other existing processes where Part D enrollee liability amounts are utilized. Industry claims processing solutions must include:

- Enabling \$0 OOP cost sharing at the POS for all covered Part D drugs within the timeliness standards for processing an individual's election into the program with the plan, as described in section 70 (does not apply to dates of service prior to election date with some exceptions outlined below in subsequent sections);
- Allowing for COB claims processing with supplemental payers to Part D as if the Medicare Prescription Payment Plan did not apply, meaning Part D sponsors are only to cover the final participant liability amount after benefits from supplemental payers are processed by the pharmacy;

- Minimal participant involvement at the POS to enable \$0 OOP cost sharing (and COB when applicable) after opting into the program, as the primary responsibility for appropriate claims processing is between the Part D sponsor and the pharmacy;
- No impact to PDE cost/payment field reporting, meaning PDE financials must reflect participant and plan liability amounts as if the Medicare Prescription Payment Plan did not apply;
- No impact to TrOOP accumulation, meaning Part D sponsors must accumulate TrOOP balances as if the Medicare Prescription Payment Plan did not apply<sup>10</sup>; and,
- No impact to prescriber or participant real-time benefit tools, meaning participant liability amounts must be represented as if the Medicare Prescription Payment Plan did not apply. If the individual has opted into the program, Part D sponsors can consider providing patient costs that reflect the program in their participant real-time benefit tool, as long as the total expected OOP liability is clearly communicated to the individual. If the individual has not opted into the program, the participant real-time benefit tool could be used to alert the individual about the program (either generally or conditionally when the participant real-time benefit tool returns a liability amount over a particular dollar amount).

CMS seeks feedback regarding these requirements, including any specific electronic claims processing methodology preferred by interested parties that would accomplish the goals of the program most efficiently and effectively for all parties to ensure timely implementation in 2025 and improve the Medicare Prescription Payment Plan participant experience.

## 50.2 Pharmacy Transaction Costs

Any additional transaction fees or other costs pharmacies incur from processing claims under the Medicare Prescription Payment Plan or otherwise related to such program are considered allowable pharmacy costs associated with the dispensing of a covered Part D drug that may be paid through applicable dispensing fees.

## 50.3 Requirements for Different Pharmacy Types

Except as otherwise required in this guidance or under other applicable requirements, all Medicare Prescription Payment Plan requirements are the same for every pharmacy type, including mail-order, home infusion, specialty, and long-term care pharmacies. CMS seeks feedback regarding unique scenarios that may arise related to different pharmacy types participating in the program that may require alternative payment or claims processing standards.

## 50.4 Paper Claims

Except for the election-related circumstances listed in section 70 of this guidance, Part D sponsors are not required to retroactively include under this program paper claims submitted to the Part D sponsor by a Medicare Prescription Payment Plan participant. CMS seeks input on

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<sup>10</sup> Note that the IRA amended section 1860D–2(b)(4)(C) of the Act to modify the definition of incurred costs starting in 2025.

whether or how paper claims should be processed for Medicare Prescription Payment Plan participants.

## **60. Requirements Related to Part D Enrollee Outreach**

Under section 1860D–2(b)(2)(E)(v) of the Act, both CMS and Part D sponsors are required to provide Medicare Prescription Payment Plan information and educational materials to Part D enrollees. In addition to the general outreach and education requirements (section 60.1), CMS is also requiring Part D sponsors to engage in multiple forms of targeted outreach, as discussed in section 60.2.

### **60.1 General Part D Enrollee Outreach Requirements**

Under section 1860D–2(b)(2)(E)(v)(III)(bb) of the Act, Part D sponsors must notify prospective Part D enrollees of the option to opt into the Medicare Prescription Payment Plan in promotional materials prior to the plan year. Under section 1860D–2(b)(2)(E)(v)(III)(cc), Part D sponsors must also include information on the Medicare Prescription Payment Plan in Part D enrollee educational materials. As such, Part D sponsors must provide clear information about the program to Part D enrollees through communication and marketing materials during open enrollment.

CMS will provide additional guidance on marketing and communications procedures and content in the next phase of guidance. This will include guidance on communications at the pharmacy, model language, and standardized materials (where appropriate), including language about the availability of the LIS program under Part D. CMS requests feedback on which Part D enrollee communication materials would benefit from CMS templates, samples, or model language.

In addition, CMS will develop tools (e.g., model documents and training materials) to help Part D enrollees decide whether the program is right for them.

### **60.2 Targeted Part D Enrollee Outreach Requirements**

As mentioned elsewhere in this guidance, while this program is open to all Part D enrollees, Part D enrollees incurring high OOP costs earlier in the plan year are generally more likely to benefit. Given this, in addition to the general outreach and education required under section 1860D–2(b)(2)(E)(v)(III) of the Act, Part D sponsors must also undertake targeted outreach, both prior to and during the plan year, to Part D enrollees likely to benefit from the Medicare Prescription Payment Plan. This includes the pharmacy notification process (as outlined in section 1860D–2(b)(2)(E)(v)(III)(dd) of the Act and section 60.2.4 of this guidance) and outreach directly to identified Part D enrollees (section 60.2.3).

#### ***60.2.1 Identification of Part D Enrollees Who Are Likely to Benefit***

Under section 1860D–2(b)(2)(E)(v)(III)(dd), Part D sponsors must have a mechanism to notify a pharmacy when a Part D enrollee incurs OOP costs with respect to covered Part D drugs that

make it likely the enrollee may benefit from participating in the program. While the statute requires this notification, it does not outline the specific criteria or define the profile of someone who is likely to benefit under the program. CMS developed a standardized framework for assessing “likely to benefit,” which will be used to inform targeted outreach both prior to and during the plan year. CMS recognizes, however, that an individual Part D enrollee may find that they would personally benefit from the program even if they would not be identified as likely to benefit under this particular standardized framework. Those individuals are certainly permitted to opt into the program. The definition and framework for “likely to benefit” presented in this section is specifically for identifying Part D enrollees for targeted outreach and communication in the absence of any information regarding an individual’s specific financial circumstances.

In retrospective modeling of PDE data, CMS found that to be “likely to benefit” from the program, the Part D enrollee would have to incur some level of substantial OOP costs; further, the Part D enrollee’s highest monthly OOP cost incurred would be more than the highest monthly paid amount under the Medicare Prescription Payment Plan (if the program had applied). CMS used this approach to identify “likely to benefit” because it focuses on addressing Part D enrollees’ potential cash-flow concerns by lowering their maximum OOP costs in a month (and limiting the potential for participants to be faced with Medicare Prescription Payment Plan monthly payments that may initially provide substantial financial relief but later, due to timing constraints, result in monthly beneficiary payments that are higher than they would have been absent the program). This approach strictly compares the monthly OOP amounts with and without the Medicare Prescription Payment Plan, and without any subjective assessments of what amount might be beneficial to an individual Part D enrollee. In addition, it is easy to explain and relatively simple to use for the first year of the program. 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.

As discussed in section 30 of this guidance, the maximum monthly cap is calculated for each month a participant is in the program, and the amount billed to a participant will change each month if the participant continues to incur new OOP costs. The calculations do not change the total amount that a participant will pay over the course of the year; instead, participants in the Medicare Prescription Payment Plan are able to spread their OOP costs over the course of the plan year in monthly amounts calculated according to the statutory formula.

Given these requirements, Part D enrollees with high OOP costs earlier in the plan year, in particular, are more likely to benefit from participating. For example, in 2025, an individual with no previously incurred costs who opts into the program in January will have a maximum monthly cap for the first month of \$166.67 and a full 12 months of billing periods over which to spread costs. If that same individual were to opt into the program in September (assuming no previously incurred costs), their maximum monthly cap for the first month would be \$500; newly incurred OOP costs would be spread over four billing periods (September through December). The table below provides an example of a Part D enrollee who is likely to benefit from the program. In this example, the individual opts into the Medicare Prescription Payment Plan and begins filling a high-cost prescription in January 2025. Because they reach the annual OOP threshold in April, they incur no new OOP costs over the remainder of the year and have the

ability to spread costs incurred early in the year over the entire 12 months of the plan year. In alignment with the standardized “likely to benefit” concept discussed above, the highest monthly OOP payment amount without the Medicare Prescription Payment Plan is \$500.00, which is greater than the highest monthly payment amount under the Medicare Prescription Payment Plan of \$181.32.

<b>Month</b>	<b>OOP Costs Incurred</b>	<b>Maximum Monthly Cap</b>	<b>Monthly Participant Payment</b>	<b>Remaining Balance</b>
January	\$500.00	\$166.67	\$166.67	\$333.33
February	\$500.00	\$75.76	\$75.76	\$757.57
March	\$500.00	\$125.76	\$125.76	\$1,131.81
April	\$500.00	\$181.31	\$181.31	\$1,450.50
May	\$0.00	\$181.31	\$181.31	\$1,269.19
June	\$0.00	\$181.31	\$181.31	\$1,087.88
July	\$0.00	\$181.31	\$181.31	\$906.57
August	\$0.00	\$181.31	\$181.31	\$725.26
September	\$0.00	\$181.32	\$181.32	\$543.94
October	\$0.00	\$181.31	\$181.31	\$362.63
November	\$0.00	\$181.32	\$181.32	\$181.31
December	\$0.00	\$181.31	\$181.31	\$0.00
<b>TOTAL</b>	<b>\$2,000.00</b>		<b>\$2,000.00</b>	

In comparison to the example above, if an individual incurs a similar amount of OOP costs but they opt into the Medicare Prescription Payment Plan and begin filling prescriptions in September as opposed to January, the individual would not hit the annual OOP threshold until December and would have no remaining time in the plan year to spread their costs. Because the monthly maximum cap calculation updates each month to include newly incurred OOP costs in that month, participation in the Medicare Prescription Payment Plan results in early payments that provide substantial financial relief (e.g., \$166.67 compared to \$500.00 in October) but later, due to timing constraints, results in monthly payments that are higher than they would have been absent the program (e.g., \$916.66 compared to \$500.00 in December). In the table below, the highest monthly OOP payment amount without the Medicare Prescription Payment Plan is \$500.00, which is lower than the highest monthly payment amount under the Medicare Prescription Payment Plan of \$916.66; this participant is thus not likely to benefit from the program.

<b>Month</b>	<b>OOP Costs Incurred</b>	<b>Maximum Monthly Cap</b>	<b>Monthly Participant Payment</b>	<b>Remaining Balance</b>
January	\$0.00	N/A	\$0.00	\$0.00
February	\$0.00	N/A	\$0.00	\$0.00
March	\$0.00	N/A	\$0.00	\$0.00
April	\$0.00	N/A	\$0.00	\$0.00
May	\$0.00	N/A	\$0.00	\$0.00

<b>Month</b>	<b>OOP Costs Incurred</b>	<b>Maximum Monthly Cap</b>	<b>Monthly Participant Payment</b>	<b>Remaining Balance</b>
June	\$0.00	N/A	\$0.00	\$0.00
July	\$0.00	N/A	\$0.00	\$0.00
August	\$0.00	N/A	\$0.00	\$0.00
September	\$500.00	\$500.00	\$500.00	\$0.00
October	\$500.00	\$166.67	\$166.67	\$333.33
November	\$500.00	\$416.67	\$416.67	\$416.66
December	\$500.00	\$916.66	\$916.66	\$0.00
<b>TOTAL</b>	<b>\$2,000.00</b>		<b>\$2,000.00</b>	

Part D enrollees with low-to-moderate recurring OOP drug costs (e.g., maintenance drugs whose annual costs are not expected to exceed the OOP threshold) are also not likely to benefit from the Medicare Prescription Payment Plan because their costs are already distributed evenly throughout the year.

The table below provides an example of an individual who is not likely to benefit from the program. The participant opts into the Medicare Prescription Payment Plan and begins filling multiple monthly maintenance drugs in January 2025. They do not reach the annual OOP threshold in 2025. Because the monthly maximum cap calculation updates each month to include newly incurred OOP costs in that month, participation in the Medicare Prescription Payment Plan results in early payments that provide substantial financial relief (e.g., \$5 compared to \$55 in February) but later, due to timing constraints, results in monthly payments that are higher than they would have been absent the program (e.g., \$166.09 compared to \$55 in December). The highest monthly OOP payment amount without the Medicare Prescription Payment Plan was \$55.00, which is lower than the highest monthly payment amount under the Medicare Prescription Payment Plan of \$166.09; this participant is thus not likely to benefit from the program.

<b>Month</b>	<b>OOP Costs Incurred</b>	<b>Maximum Monthly Cap</b>	<b>Monthly Participant Payment</b>	<b>Remaining Balance</b>
January	\$55.00	\$166.67	\$55.00	\$0.00
February	\$55.00	\$5.00	\$5.00	\$50.00
March	\$55.00	\$10.50	\$10.50	\$94.50
April	\$55.00	\$16.61	\$16.61	\$132.89
May	\$55.00	\$23.49	\$23.49	\$164.40
June	\$55.00	\$31.34	\$31.34	\$188.06
July	\$55.00	\$40.51	\$40.51	\$202.55
August	\$55.00	\$51.51	\$51.51	\$206.04
September	\$55.00	\$65.26	\$65.26	\$195.78
October	\$55.00	\$83.59	\$83.59	\$167.19
November	\$55.00	\$111.10	\$111.10	\$111.09

Month	OOP Costs Incurred	Maximum Monthly Cap	Monthly Participant Payment	Remaining Balance
December	\$55.00	\$166.09	\$166.09	\$0.00
<b>TOTAL</b>	<b>\$660.00</b>		<b>\$660.00</b>	

In comparison to the example above, if an individual had similar total OOP costs, but they were incurred as a single acute event instead of recurring monthly fills, the individual would have an opportunity to spread those costs over the remaining months in the year. This participant would be considered likely to benefit from the program; the highest monthly OOP payment amount without the Medicare Prescription Payment Plan was \$660.00, which is greater than the highest monthly payment amount under the Medicare Prescription Payment Plan of \$200.00.

Month	OOP Costs Incurred	Maximum Monthly Cap	Monthly Participant Payment	Remaining Balance
January	\$0	N/A	\$0	\$0.00
February	\$0	N/A	\$0	\$0.00
March	\$660.00	\$200.00	\$200.00	\$460.00
April	\$0.00	\$51.11	\$51.11	\$408.89
May	\$0.00	\$51.11	\$51.11	\$357.78
June	\$0.00	\$51.11	\$51.11	\$306.67
July	\$0.00	\$51.11	\$51.11	\$255.56
August	\$0.00	\$51.11	\$51.11	\$204.45
September	\$0.00	\$51.11	\$51.11	\$153.34
October	\$0.00	\$51.11	\$51.11	\$102.23
November	\$0.00	\$51.12	\$51.12	\$51.11
December	\$0.00	\$51.11	\$51.11	\$0.00
<b>TOTAL</b>	<b>\$660.00</b>		<b>\$660.00</b>	

While unique individual financial situations may make participation in the program beneficial at any point in the plan year (with the possible exception of December, as OOP costs incurred in December cannot be spread over multiple months), generally, those with high OOP drug costs early in the year (including recurring costs) are likely to benefit from the Medicare Prescription Payment Plan.

#### *60.2.2 Targeted Part D Enrollee Notification Prior to POS*

In addition to notifying all prospective Part D enrollees about the option to opt into the Medicare Prescription Payment Plan, Part D sponsors must also conduct outreach directly to individuals who are likely to benefit from the program, both prior to and during the plan year.

In part two guidance, CMS will specify parameters for identifying enrollees prior to the plan year who are likely to benefit. These parameters will build upon the concept of identifying Part D enrollees who are “likely to benefit” from the program, as discussed in section 60.2.1.

### 60.2.3 Targeted Part D Enrollee Notification at POS

Under section 1860D–2(b)(2)(E)(v)(III)(dd), Part D sponsors must have a mechanism to notify a pharmacy when a Part D enrollee incurs OOP costs with respect to covered Part D drugs that make it likely the enrollee may benefit from participating in the program. Furthermore, section 1860D–2(b)(2)(E)(v)(III)(ee) requires Part D sponsors to ensure that a pharmacy, after receiving such a notification from the plan sponsor, informs the Part D enrollee that it is likely that the Part D enrollee may benefit from the Medicare Prescription Payment Plan.

Using the concept of “likely to benefit” discussed in section 60.2.1, CMS modeled how various potential POS notification thresholds performed in identifying Part D enrollees who would meet the above definition of “likely to benefit” based on 2021 PDE data. As guided by the statute’s reference to OOP costs, CMS analyzed 2021 PDE records for patterns in drug spend and patient pay that would make a Part D enrollee likely to benefit from the Medicare Prescription Payment Plan. The analysis used only OOP costs that would be known at the POS, not historical costs, to align with what the Part D sponsor and pharmacy would be communicating at a point in time. In the analysis, CMS excluded Part D enrollees who first met the POS notification threshold in December, as OOP costs incurred in December cannot be spread over multiple months.

Our modeling and approach in this guidance is based on the OOP costs for any single prescription counting toward a potential threshold. As a sensitivity analysis, CMS also examined the performance of various potential threshold amounts by counting OOP costs for prescriptions filled on the same day toward a single POS total, assuming that those prescriptions would have been paid for during the same pharmacy visit. While counting OOP costs for all prescriptions filled on the same day results in more Part D enrollees being notified, the differential is less than 200,000 Part D enrollees at the lower threshold and even smaller at the highest threshold. Since the results were similar in scale and relative counts for each possible threshold, our current guidance is to use the OOP cost of any single prescription as a trigger for the POS notification for simplicity of operations with minimal impact on Part D enrollees. However, CMS seeks comment on whether it would be preferable to use a value based on the OOP costs for all prescriptions filled in a single day.

Whether the pharmacy notification process is based on OOP costs for a single prescription or all prescriptions within a single day, there is limited visibility into possible future prescription costs, and therefore almost any threshold has the potential to identify Part D enrollees whose subsequent cost patterns will cause them to no longer meet the definition of likely to benefit. Higher POS thresholds identify a smaller pool of Part D enrollees but increase the probability that those who would receive the notification would continue to meet the definition of likely to benefit. The table below summarizes key findings from CMS’s analyses of POS thresholds based on a single prescription.

<b>Single Prescription OOP Cost Threshold</b>	<b>Part D Enrollees Identified as Likely to Benefit*</b>	<b>% Actually Would Have Benefited</b>
\$400	2.2 million	2.0 million (91%)
\$500	1.1 million	1.0 million (95%)
\$600	597k	585k (98%)

<b>Single Prescription OOP Cost Threshold</b>	<b>Part D Enrollees Identified as Likely to Benefit*</b>	<b>% Actually Would Have Benefited</b>
\$700	435k	432k (99.3%)
\$800	373k	372k (99.6%)
\$900	330k	330k (99.9%)
\$1,000	306k	306k (99.99%)

\*Number of Part D enrollees identified in retrospective analyses using 2021 PDE data

The table below displays the results from the sensitivity analysis, which counts OOP costs for all prescriptions filled on the same day toward a single POS total.

<b>Single Day OOP Cost Threshold</b>	<b>Part D Enrollees Identified as Likely to Benefit*</b>	<b>% Actually Would Have Benefited</b>
\$400	2.4 million	2.2 million (90%)
\$500	1.3 million	1.2 million (95%)
\$600	696k	681k (98%)
\$700	495k	490k (99%)
\$800	410k	408k (99.5%)
\$900	355k	354k (99.8%)
\$1,000	323k	323k (99.99%)

\*Number of Part D enrollees identified in retrospective analyses using 2021 PDE data

In setting a POS threshold, CMS strives to balance the desire to identify individuals with potential cash-flow concerns at the pharmacy and provide them key information about a program that may benefit them while ensuring precision in the notification (i.e., limiting the potential for participants to be faced with Medicare Prescription Payment Plan monthly payments that initially provide substantial financial relief but later, due to timing constraints, result in monthly payments that are higher than they would have been absent the program). In addition, given that a POS enrollment option is not likely for 2025, it will be of particular import that Part D enrollees who are likely to benefit from this program are reached out to prior to receiving a POS notification, to minimize the need to leave the pharmacy without their prescriptions. CMS is providing a range of thresholds in the tables above but notes that above the \$700 threshold, there is minimal improvement in the proportion of those notified who would actually benefit from the program. As a result, CMS seeks comment on the range of potential POS notification thresholds from \$400 to \$700, along with specific factors for CMS to take into consideration when determining the threshold for 2025, including using a single prescription versus single day accumulation to count toward the threshold.

#### *60.2.4 POS Notification Requirements*

CMS is proposing to establish the requirements below for identifying Part D enrollees at the POS who are likely to benefit from participating in the program. Under section 1860D–2(b)(2)(E)(v)(III)(dd) of the Act, Part D sponsors are required to have in place a mechanism to notify the pharmacy when a Part D enrollee who has not already opted into the Medicare Prescription Payment Plan incurs OOP costs with respect to a covered Part D drug that make it likely the Part D enrollee may benefit from the program. As articulated above, for the pharmacy

notification requirement, CMS is proposing to base the determination of whether an enrollee is likely to benefit from participating in the program based on when they incur OOP costs for a single prescription that equal or exceed the POS threshold.

Part D sponsors must notify pharmacies when a Part D enrollee's OOP costs meet these criteria at the POS and require the pharmacy to inform the Part D enrollee that they may benefit from the program and how to opt in if the Part D enrollee would like to participate in the program. CMS will provide additional guidance on the contents of notifications as well as model language for educational materials in the next phase of guidance and welcomes input on these topics.

A Part D enrollee is unlikely to benefit from opting in during December, the last month of the plan year, because OOP costs incurred in that month cannot be spread over more than one month.<sup>11</sup> As such, a Part D enrollee should not be notified that they are likely to benefit in the last month of the plan year. Additionally, participants who have already opted into the Medicare Prescription Payment Plan should not be notified about opting into the program while their participation is in effect. If a prescription is picked up by another person who is not the Part D enrollee, the Part D sponsor must require the pharmacy to provide the person who is picking up the prescription with information about the program when the pharmacy would have been required to provide such information if the Part D enrollee had picked up the prescription. However, only the Part D enrollee or their legal representative may opt into the program. Nothing in this guidance precludes a pharmacy from educating a Part D enrollee about this program, regardless of whether the enrollee's cost-sharing reaches the POS threshold for required notification.

Part D sponsors must notify a pharmacy when a Part D enrollee incurs OOP costs for a single prescription that equal or exceed the POS threshold, regardless of whether the Part D enrollee receives prescriptions through a retail pharmacy or through a mail order, home infusion, specialty, or long-term care pharmacy. CMS is aware that claims processing and billing practices may differ for certain unique pharmacy scenarios and seeks comment on whether and what alternative notification processes or standards should be established for different types of pharmacies (for example, requiring notification via a phone call as opposed to via a paper notice).

Additional specifics around the pharmacy notification process will be forthcoming in part two guidance.

## **70. Requirements Related to Part D Enrollee Election**

### **70.1 Part D Enrollee Eligibility**

Under section 1860D–2(b)(2)(E)(i) of the Act, Part D sponsors must provide the option to opt into the Medicare Prescription Payment Plan to all Part D enrollees, including enrollees who are LIS-eligible individuals.

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<sup>11</sup> Except for non-calendar year Employer Group Waiver Plans (EGWPs), which would apply the last month of their specific plan year.

The program is voluntary for any Part D enrollee to opt into. In addition, Part D sponsors cannot set a minimum OOP cost sharing amount that Part D enrollees must incur to participate. As described above, Part D sponsors must identify Part D enrollees likely to benefit and educate those enrollees on the impacts of potentially participating in the Medicare Prescription Payment Plan.

Under section 1860D–2(b)(2)(E)(v)(II) of the Act, a Part D enrollee may opt into the Medicare Prescription Payment Plan prior to the beginning of the plan year or in any month during the plan year. In addition, under section 1860D–2(b)(2)(E)(v)(III)(aa) of the Act, Part D sponsors may not restrict the application of the Medicare Prescription Payment Plan benefit to specific Part D covered drugs. To minimize potential confusion and operational challenges, CMS is further clarifying that once an individual has opted into the program, OOP cost sharing for all covered Part D drugs must be included until the participant reaches the OOP threshold or opts out of the Medicare Prescription Payment Plan.

## 70.2 Interactions Between LIS and Medicare Prescription Payment Plan

The IRA expanded the LIS program so that, beginning in 2024, beneficiaries with incomes up to 150% of the federal poverty limit and who meet the resource standard at either of sections 1860D-14(a)(3)(D) or (E) of the Act will be eligible for the full LIS benefit. Prior to 2024, the full LIS benefit was available only to enrollees earning less than 135% of the federal poverty level. This subsidy provides for \$0 premiums and low-cost, fixed copayments for covered prescription drugs.

Considering this change, and the potential reductions in OOP costs from enrolling in LIS, it is critical that Part D enrollees eligible for the LIS program are encouraged to apply. While the statute requires that an LIS enrollee must have the option to become a Medicare Prescription Payment Plan participant, individuals with low, stable drug costs (such as LIS enrollees) are not likely to benefit from the program. (Please refer to section 60.2.1 for additional detail around identification of Part D enrollees who are likely to benefit.) Further, LIS enrollment, for those who qualify, is more advantageous than participation in the Medicare Prescription Payment Plan alone. 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. In this scenario, the participant may wish to continue to pay the balance from the early, high-cost drugs in monthly payments through the Medicare Prescription Payment Plan. However, in general, participation in the Medicare Prescription Payment Plan is unlikely to benefit LIS enrollees.

It is important that Part D sponsors inform any individual interested in the Medicare Prescription Payment Plan of potential eligibility for the LIS program. As a result, throughout this guidance, CMS is requiring Part D sponsors to provide individuals with information about both the Medicare Prescription Payment Plan and LIS program prior to the plan year and upon opting into the Medicare Prescription Payment Plan (see sections 60 and 70). In addition, section 70.3.6 contains proposed special requirements under the Medicare Prescription Payment Plan when there is retroactive LIS eligibility and enrollment and encourages Part D sponsors to provide

additional education at the time of the LIS status change. Finally, section 80.2.1 states that when a Part D sponsor sends an initial notice that a participant has failed to pay the billed amount under the Medicare Prescription Payment Plan, the notice must provide information and encouragement to apply for the LIS program.

In draft part two guidance, CMS will provide additional requirements and model language about the Medicare Prescription Payment Plan, enrollees' rights, and Part D sponsor responsibilities related to Part D enrollees participating in the LIS program. CMS seeks comment on additional ways to conduct outreach to Part D enrollees who may be eligible for the LIS program or are already in the LIS program to educate them about the implications of participating in the each of the programs. This outreach will be designed to help individuals determine which program(s) will be most suitable for their unique circumstances.

### 70.3 Election Procedures

#### 70.3.1 *Format of Election Requests*

Although participation in the Medicare Prescription Payment Plan has no bearing on an individual's enrollment in a Part D plan, program election requirements are guided by the requirements in the Eligibility, Enrollment, and Disenrollment chapter of the Medicare Prescription Drug Benefit Manual, as applicable.<sup>12</sup> Specifically, the Part D enrollee or their legal representative must complete an election request to opt into the Medicare Prescription Payment Plan. Part D sponsors must consider Medicare Prescription Payment Plan election requests, regardless of the election mechanism.

Part D sponsors must have the following mechanisms available to Part D enrollees who wish to opt into the Medicare Prescription Payment Plan:

- An election option through the Part D (or MA-PD) plan enrollment process;
- A paper option that can be faxed or mailed;
- A toll-free telephone number, that must provide the individual with evidence the election request was received (e.g., a confirmation number); and
- A website application that must provide the individual with evidence the election request was received (e.g., a confirmation number).

Each telephonic election request must be recorded and include statements of the Part D enrollee's agreement and a verbal attestation of the intent to opt into the Medicare Prescription Payment Plan. If the request is made by an individual other than the Part D enrollee, the recording must include an attestation regarding the individual's authority to complete the request, in addition to the required information. All telephonic election recordings must be reproducible and maintained consistent with CMS requirements in the Eligibility, Enrollment, and Disenrollment chapter of the Medicare Prescription Drug Benefit Manual.

The Part D enrollee signature or legal representative signature for a paper election request is satisfied with a pen-and-ink signature. A telephone request is satisfied with a verbal attestation of

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<sup>12</sup> Refer to Medicare Prescription Drug Benefit Manual; [Chapter 3 - Eligibility, Enrollment and Disenrollment](#).

intent to opt in, and an electronic request is satisfied with an electronic signature or a clear and distinct step that requires the applicant to activate an “Opt In Now,” or “I Agree,” type of button or tool.

The electronic election mechanism must capture an accurate time and date stamp at the time the applicant executes the electronic signature. If a legal representative is completing this request, they must attest that they have authority to make the request and that proof of this authority is available upon request.

If an election request is submitted and a signature is not included, the Part D sponsor must verify with the Part D enrollee or their legal representative, through the mail (if the enrollee has opted out of phone or electronic communications), otherwise through a phone call or electronic communication, and document the contact within 10 calendar days rather than return the request as incomplete. Part D sponsors are expected to keep a copy of the election request and provide a copy upon request by the Part D enrollee. The Part D sponsor is responsible for the security and privacy of the information provided by the applicant and for the timely disclosure of any breaches in accordance with applicable law.

### *70.3.2 Completion of Election Request*

Consistent with section 1860D–2(b)(2)(E)(v)(II) of the Act, a Part D enrollee may opt into the Medicare Prescription Payment Plan prior to the beginning of the plan year or in any month during the plan year. The Part D enrollee, or their legal representative, must complete an election request, provide the required information to the Part D sponsor, and be approved by the Part D sponsor to opt into the Medicare Prescription Payment Plan.

Election request elements should be limited to only those necessary for processing the election request, including:

- The name of the individual eligible for Part D;
- The individual’s Medicare Beneficiary Identifier; and
- A record of the individual and/or their legal representative’s agreement to the Part D sponsor’s terms and conditions.

### *70.3.3 Processing Election Request at the Time of Enrollment in a New Plan*

Part D sponsors must allow Part D enrollees to opt into the Medicare Prescription Payment Plan during Part D plan annual enrollment periods, initial Part D enrollment periods, and special Part D enrollment periods. Specifically, the option to opt into the Medicare Prescription Payment Plan must be integrated into the materials and procedures for the Part D plan enrollment in a new plan. When a Part D sponsor receives a program election request through the plan enrollment process, the Part D sponsor will process the request within 10 calendar days of receipt, or the number of calendar days before the plan enrollment starts, whichever is shorter.

The Medicare Prescription Payment Plan application date is the date the Part D sponsor initially receives the election request. Upon receiving a Medicare Prescription Payment Plan election

request, a Part D sponsor must acknowledge receipt of the request electronically or by mail within 10 days of receipt and provide:

- An approval of the request and effective date when the individual starts in the Medicare Prescription Payment Plan;
- A request for additional information; or
- A denial of the request through a written notice of denial.

When a request to participate in the Medicare Prescription Payment Plan is approved, the Part D sponsor must provide the participant with the following (CMS will provide more specific information, including model language in the next round of guidance):

- An overview of the program and participant rights, responsibilities, and protections, including information on procedures for involuntary termination, reinstatement, and resolution of grievances;
- Examples of calculations of the maximum monthly cap in the first month and subsequent months, including example calculations describing scenarios in which the program would not be beneficial to an individual; and
- General information about applying for the LIS program and how to enroll (as an additional or alternative avenue for addressing prescription drug costs), noting that LIS enrollment, for those who qualify, is more advantageous than participation in the Medicare Prescription Payment Plan alone; and
- The effective date of the individual's participation in the Medicare Prescription Payment Plan.

If a Part D sponsor receives an election request that does not have all necessary elements required to consider it complete, the sponsor must not immediately deny the request. The Part D sponsor must contact the individual to request the additional documentation necessary to process the request within 10 calendar days of receipt of the incomplete election request.

Additional documentation to make the program election request complete must be received by the Part D sponsor within 21 calendar days of the request for additional information. The Part D sponsor may deny the election request if the requisite information is not received from the individual in that timeframe.

If an individual's request to participate in the Medicare Prescription Payment Plan is denied, the Part D sponsor must send notice of the denial to the individual that includes an explanation of the reason for denial (such as failing to submit the information requested within the timeframe listed on the request) and a description of the grievance process available to the individual within 10 calendar days of the denial or the expiration of the timeframe for submission of additional information. See section 90 for additional information on participant dispute requirements.

#### *70.3.4 Processing Election Request Before a Plan Year Begins While Remaining in Same Plan*

Part D sponsors must ensure each Part D enrollee has the chance to opt into the program even if they are staying in their current plan or have not yet made a decision for the next plan year. Therefore, the opportunity to opt into the Medicare Prescription Payment Plan must be integrated

into annual notices when Part D enrollees receive materials about changes for the upcoming plan year.

It is important for the Part D sponsor to process Medicare Prescription Payment Plan requests promptly. When a Part D sponsor receives a program election request for the next plan year, and the Part D enrollee has decided to remain in the same plan or has not made an enrollment decision, the Part D sponsor will process the request within 10 calendar days of receipt, or the number of calendar days before the plan enrollment starts, whichever is shorter.

The Medicare Prescription Payment Plan application date is the date the Part D sponsor initially receives the election request. Upon receiving a Medicare Prescription Payment Plan election request, a Part D sponsor must acknowledge receipt of the request electronically or by mail within 10 days of receipt and provide:

- An approval of the request and effective date when the individual starts in the Medicare Prescription Payment Plan;
- A request for additional information; or
- A denial of the request through a written notice of denial.

When a request to participate in the Medicare Prescription Payment Plan is approved, the Part D sponsor must provide the participant with the following (CMS will provide more specific information in the next round of guidance):

- An overview of the program and participant rights, responsibilities, and protections, including information on procedures for involuntary termination, reinstatement, and resolution of grievances;
- Examples of calculations of the maximum monthly cap in the first month and subsequent months, including example calculations describing scenarios in which the program would not be beneficial to an individual;
- General information about applying for the LIS program and how to enroll (as an additional or alternative avenue for addressing prescription drug costs), noting that LIS enrollment, for those who qualify, is more advantageous than participation in the Medicare Prescription Payment Plan alone; and
- The effective date of the individual's participation in the Medicare Prescription Payment Plan.

If a Part D sponsor receives an election request that does not have all necessary elements required to consider it complete, the sponsor must not immediately deny the request. The Part D sponsor must contact the individual to request the additional documentation necessary to process the request within 10 calendar days of receipt of the incomplete election request.

Additional documentation to make the program election request complete must be received by the Part D sponsor within 21 calendar days of the request for additional information. The Part D sponsor may deny the election request if the requisite information is not received from the individual in that timeframe.

If an individual's request to participate in the Medicare Prescription Payment Plan is denied, the Part D sponsor must send notice of the denial to the individual that includes an explanation of the

reason for denial (such as failing to submit the information requested within the timeframe listed on the request) and a description of the grievance process available to the individual within 10 calendar days of the denial or the expiration of the timeframe for submission of additional information. See section 90 for additional information on participant dispute requirements.

#### *70.3.5 Processing Election Request During a Plan Year*

When a Part D enrollee is already enrolled in a Part D plan and requests to opt into the Medicare Prescription Payment Plan during the plan year, Part D sponsors must process the election request within 24 hours to prevent delays in dispensing drugs to individuals when they opt into the program. CMS is proposing to establish a 24-hour requirement for processing election requests during the plan year.

The proposed 24-hour requirement is consistent with existing requirements for the processing of expedited coverage determinations at 42 CFR § 423.572. As such, CMS believes an identical timeframe will be operationally feasible for processing election requests. Requiring an efficient election process during the plan year will also ensure that individuals who may benefit from the program do not face unnecessary barriers to accessing their prescriptions. However, CMS solicits comments on whether there is an interim solution that Part D sponsors could implement to prevent Part D enrollees from waiting 24-hours to receive their prescription at \$0 out of pocket while waiting for their election into the program to process.

The Medicare Prescription Payment Plan application date and time is the date and time the Part D sponsor initially receives the election request. Upon receiving a Medicare Prescription Payment Plan election request, a Part D sponsor must communicate within 24 hours:

- An approval of the request and effective date when the individual starts in the Medicare Prescription Payment Plan;
- A request for additional information; or
- A denial of the request through a written notice of denial.

When the individual's election into the Medicare Prescription Payment Plan has been approved, the Part D sponsor must provide the new program participant with the following (CMS will provide more specific information, including model language in the next round of guidance):

- An overview of the program and participant rights, responsibilities, and protections, including information on procedures for involuntary termination, reinstatement, and resolution of grievances;
- Examples of calculations of the maximum monthly cap in the first month and subsequent months, including example calculations describing scenarios in which the program would not be beneficial to an individual;
- General information about applying for the LIS program and how to enroll (as an additional or alternative avenue for addressing prescription drug costs), noting that LIS enrollment, for those who qualify, is more advantageous than participation in the Medicare Prescription Payment Plan alone; and
- The effective date of the individual's participation in the Medicare Prescription Payment Plan.

Part D sponsors must make reasonable efforts to collect additional information and process the election request within 24 hours of receiving the necessary information. CMS seeks comment on these standards for completing election into the program. Further, in section 70.3.9 below, CMS requests input on the feasibility of real-time POS election.

If an individual's request to participate in the Medicare Prescription Payment Plan is denied, the Part D sponsor must send notice of the denial to the individual that includes an explanation of the reason for denial (such as failing to submit the information requested within the timeframe listed on the request) and a description of the grievance process available to the individual within 24 hours of the denial or the expiration of the timeframe for requested additional information. See Section 90 for additional information on participant dispute requirements.

#### *70.3.6 Retroactive LIS Eligibility and Election*

As LIS applicant status is usually effective retroactively, CMS regulations at 42 CFR § 423.800(c) apply if a subsidy-eligible individual opts into the Medicare Prescription Payment Plan. These regulations require Part D sponsors to reimburse subsidy-eligible individuals, and any organizations paying cost sharing on behalf of such individuals, any excess premium or OOP cost sharing paid by the individual or organization for Medicare Prescription Payment Plan amounts as appropriate under § 423.800(c).

Under the timeframes specified at 42 CFR §§ 423.800(e) and 423.466(a), Part D sponsors must process retroactive claims and premium adjustments for LIS-eligible individuals and make any resulting refunds and recoveries within 45 days of the Part D sponsor's receipt of complete information regarding these adjustments.<sup>13</sup> Part D sponsors and pharmacy benefit managers (PBMs) should coordinate, as necessary, to determine appropriate reimbursement amounts within the 45-day timeframe after taking into consideration the participant's Medicare Prescription Payment Plan payments already made and remaining Medicare Prescription Payment Plan outstanding balances. Specifically, if the participant paid more than what they should have paid as an LIS-eligible individual, the Part D sponsor must reimburse the participant for any excess payments and spread-out future participant costs consistent with their LIS eligibility if they remain in the program.

Part D sponsors must also provide additional consultation and education to Medicare Prescription Payment Plan participants at the time of an LIS status change, given that such a status change can significantly modify a participant's OOP obligations and thus the likelihood of them benefiting from the Medicare Prescription Payment Plan.

#### *70.3.7 Retroactive Election in the Event the Part D Sponsor Fails to Process an Election within 24 Hours*

If a Part D enrollee has fulfilled all program election requirements, but the Part D sponsor is unable to process the election into the program in the required amount of time due to no fault of the individual, the Part D sponsor must process a retroactive election back to the original date

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<sup>13</sup> Refer to Medicare Prescription Drug Benefit Manual; [Chapter 13 - Premium and Cost-Sharing Subsidies for Low-Income Individuals](#).

when the individual should have been admitted into the Medicare Prescription Payment Plan (i.e., within 24 hours of the individual providing the requisite information for election into the program). In addition, the Part D sponsor must reimburse the participant for any OOP cost sharing paid on or after that date and include those amounts, as appropriate, in a monthly bill under the program within 45 days.

#### *70.3.8 Standards for Urgent Medicare Prescription Payment Plan Election*

Part D sponsors must have a process to effectuate a retroactive election into in the Medicare Prescription Payment Plan when an enrollee has certain urgent prescription fill(s) for which they paid the associated cost sharing before the enrollee's program election was received and processed.

Under this policy, a retroactive election must be processed if all the following conditions are met:

- The Part D enrollee reasonably believes that any delay in filling the prescription(s) due to the 24-hour timeframe required to process their request to opt in in may seriously jeopardize their life, health, or ability to regain maximum function; and
- The Part D enrollee requests retroactive election within 72 hours of the date and time the urgent claim(s) were adjudicated.

Once the enrollee's Medicare Prescription Payment Plan election has been effectuated, the Part D sponsor must process the reimbursement for all cost sharing paid by the enrollee for the urgent prescription and any covered Part D prescription filled between the date of that fill and the date that the enrollee's election is effectuated within 45 days of the election date.

If the Part D sponsor determines that an enrollee failed to request retroactive election within the required timeframe or that a request for retroactive inclusion of an urgent prescription is unreasonable, it must promptly notify the individual of its determination and provide instructions on how the individual may file a grievance (see section 90).

CMS requests feedback on standards for retroactive election under the Medicare Prescription Payment Plan.

#### *70.3.9 Request for Information on Real-Time or Near-Real-Time POS Election and Other POS Needs*

CMS is also considering options to effectuate election into the Medicare Prescription Payment Plan at the POS without any delay or with only a nominal delay between the election request and effectuation beginning in 2026 or later. These options are potential alternatives or additions, for a future year, to CMS's proposed 24-hour effectuation requirement and would allow individuals to opt into the program at the pharmacy and collect their prescription in the same pharmacy transaction. CMS requests comment on the following methods of real-time and near-real-time POS election and their feasibility for 2026 or later:

## 1. Telephone-only

Under this method, CMS would require Part D sponsors to establish a telephone number for POS election into the Medicare Prescription Payment Plan. If an individual indicates to the pharmacist that they would like to opt into the program, the individual would call the number provided by the Part D sponsor. The Part D sponsor would manually effectuate the individual's election into the program and communicate the election to the PBM in real time. The PBM would then add the individual to the relevant eligibility file.

Once the individual's election is effectuated, the pharmacist would either reverse and resubmit the claim to receive the plan-specific Medicare Prescription Payment Plan NCPDP BIN/PCN, or the new program participant would receive a verbal confirmation via the phone call with the Part D sponsor providing the plan-specific BIN/PCN. The pharmacist would process the claim like a COB claim, bill any other applicable OHI, and then, lastly, bill the plan-specific BIN/PCN for the Medicare Prescription Payment Plan. The participant would then be able to collect their prescription without paying any OOP cost sharing at the POS (see section 50). Following the POS transaction, the Part D sponsor would arrange to bill the participant for their OOP amount in monthly payments in accordance with the statutory formulas.

## 2. Mobile or Web-based Application

Under this method, a mobile or web-based application would be developed by the Part D sponsor. Part D sponsors would provide real-time data to the application on an individual's prescriptions and progress toward the annual OOP threshold. The application would also include a calculator to model prospective Medicare Prescription Payment Plan payments that the individual would owe if they opt into the Medicare Prescription Payment Plan.

When a Part D enrollee receives a notification from the pharmacy that they are likely to benefit from the Medicare Prescription Payment Plan, they would be able to use the application to view information about the program and potential prospective payments. If the individual decides that they would like to opt into the program, they would be able to opt in via the application. The Part D sponsor would receive a notification that the individual has opted into the program and would effectuate election. The Part D sponsor would communicate the election to the PBM in real time. The PBM would add the new participant to the relevant eligibility file.

Then, either the pharmacist would reverse and resubmit the claim to receive the plan-specific Medicare Prescription Payment Plan BIN/PCN, or the participant would receive a confirmation through the application providing the BIN/PCN. The pharmacist would process the claim like a COB claim, bill any other applicable OHI, and bill the plan-specific BIN/PCN for the Medicare Prescription Payment Plan. The participant would then be able to collect their prescription without paying any OOP cost sharing at the POS. Following the

POS transaction, the Part D sponsor would then arrange to bill the participant for their OOP amount in monthly payments in accordance with the statutory formulas.

### 3. Clarification Code

Under this method, a new value in an existing NCPDP data field for the Medicare Prescription Payment Plan would be established. If a Part D enrollee indicates to the pharmacist that they would like to opt into the program, the pharmacist would reverse the claim and resubmit it with a specific clarification code indicating that the individual has agreed to opt into the program. The PBM would then accept the clarification code value, add the individual to the relevant eligibility file, and return a message to the pharmacy providing the plan-specific BIN/PCN.

The pharmacist would process the claim like a COB claim, bill any other applicable OHI, and bill the plan-specific BIN/PCN for the Medicare Prescription Payment Plan. The new program participant would be able to collect their prescription without paying any OOP cost sharing at the POS. The PBM would then communicate to the Part D sponsor that the individual has opted into the program. The Part D sponsor would record the participant's election and arrange to bill them for their OOP amount in monthly payments in accordance with the statutory formulas.

CMS is specifically seeking comment on:

- The potential timeline and feasibility of implementing these real-time and near-real-time POS election options for 2026;
  - What technology and processes could be leveraged to enable real-time or near-real-time POS election for 2026 and beyond;
  - The implications for Part D enrollees associated with real-time or near-real-time POS election;
  - The potential burden on interested parties associated with real-time or near-real-time POS election;
  - Whether one approach could be reasonably implemented for 2026, and a different or additional approach could be adopted in future years; and
- Other potential approaches that allow for real-time or near-real-time POS election for 2026 or future years.

#### *70.3.10 Prohibition on Part D Enrollee Discrimination*

Part D sponsors are not allowed to design their Medicare Prescription Payment Plan to discriminate against any person based on race, color, national origin, disability, sex, or age in admission to or participation in the program, whether carried out directly by the Part D sponsor or through a contractor.<sup>14</sup>

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<sup>14</sup> Refer to CMS [Accessibility & Nondiscrimination Notice](#).

In addition, under 1860D–2(b)(2)(E)(i) of the Act, Part D sponsors must provide the opportunity to opt into the Medicare Prescription Payment Plan to any Part D enrollee, including a Part D enrollee who is an LIS-eligible individual. Part D sponsors cannot discriminate against or otherwise inhibit access to the Medicare Prescription Payment Plan by any Part D enrollee. This includes a prohibition on Part D sponsors seeking to obtain a Part D enrollee’s credit report from a consumer reporting agency. Part D sponsors may not require a Part D enrollee to answer questions about or provide documentation demonstrating their ability to pay their Medicare Prescription Payment Plan balance as a condition of accepting an election into the Medicare Prescription Payment Plan.

#### 70.4 Mid-Year Plan Election Changes

Section 1860D–2(b)(2)(E)(v)(II) of the Act requires Part D sponsors to offer the Medicare Prescription Payment Plan to all Part D enrollees in any month during the year. If an individual who opted into the Medicare Prescription Payment Plan switches plans during the plan year or is reassigned by CMS, the new plan sponsor will not be required to automatically sign up the individual for the Medicare Prescription Payment Plan under the individual’s new plan. However, an individual must be able to opt into the program regardless of whether they had participated in the program under the prior plan. The prior Part D sponsor will continue to bill the participant monthly based on the participant’s accrued OOP costs while in the program under that plan. The prior Part D sponsor may also offer the participant the option to repay the full outstanding amount in a lump sum but may not require full immediate repayment.

When an individual opts into the Medicare Prescription Payment Plan after switching plans mid-year, the new Part D sponsor must calculate the individual’s monthly cap for the first month of participation under the new plan using the formula for the calculation of the maximum monthly cap in the first month, as discussed in section 30.1 of this guidance. Part D sponsors may not prevent an individual who has switched plans from opting into the Medicare Prescription Payment Plan because the individual was terminated from the program for non-payment by a different Part D sponsor or had voluntarily opted out of the program under the original plan.

Under 42 CFR § 423.464, Part D sponsors have an obligation to coordinate benefits with entities providing other prescription drug coverage to Part D eligible individuals. This obligation includes other Part D sponsors. CMS requires that all contracts participate in the plan-to-plan (P2P) process. The P2P process provides a means to coordinate correction of claims payments made by a Part D sponsor other than the Contract of Record.<sup>15</sup>

Part D sponsors should follow the P2P transition timeline and process outlined in the PDE guidance to implement the Medicare Prescription Payment Plan benefit for individuals that switch their plan in any month during the plan year.<sup>16</sup> Each plan should report and utilize the PDE data consistent with the PDE guidelines for P2P transition periods to implement the

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<sup>15</sup> Refer to CSSC Operations [PDE Plan-to-Plan \(P2P\) Reconciliation Training](#). P2P reconciliation is a financial settlement process between two Part D Sponsors in which the Contract of Record compensates the Submitting Contract for all Covered D Plan Paid (CPP) and low-income cost sharing subsidy (LICS) amounts paid by the Submitting Contract for a beneficiary enrolled in the Contract of Record.

<sup>16</sup> Refer to Medicare Prescription Drug Benefit Manual; [Chapter 14 - Coordination of Benefits](#).

Medicare Prescription Payment Plan when an individual switches plans during the plan benefit year. It should not be necessary for the plans to exchange any new data related to the program or billing to implement the program for individuals that switch plans and opt into the program under their new plan in addition to the PDE data they access and report under the current P2P transition process. This is because, under the Medicare Prescription Payment Plan, a participant's TrOOP-eligible costs will still be treated as incurred once the relevant prescription drug claim has been adjudicated. As such, the PDE data accessed under the current P2P transition process will contain all the data necessary to administer the program in the event of a mid-year plan change.

## **80. Procedures for Termination of Election, Reinstatement, and Preclusion**

### **80.1 Voluntary Terminations**

Part D sponsors must have a process to allow a participant that has opted into the Medicare Prescription Payment Plan to opt out during the plan year. Sponsors must continue to bill amounts owed under the program in monthly amounts not to exceed the maximum monthly cap according to the statutory formula for the duration of the plan year after an individual has been terminated. The Part D sponsor may also offer the participant the option to repay the full outstanding amount in a lump sum but may not require full immediate repayment. After opting out, the individual will pay any new OOP costs directly to the pharmacy.

After the individual notifies the Part D sponsor that they intend to opt out under the Part D sponsor's established process, the Part D sponsor must provide the individual with a notice of termination. Once the termination is processed, the Part D sponsor must maintain appropriate records of the termination.

### **80.2 Involuntary Terminations**

Section 1860D-2(b)(2)(E)(v)(IV)(aa) of the Act requires a Part D sponsor to terminate an individual's Medicare Prescription Payment Plan participation if that individual fails to pay their monthly billed amount. A participant will be considered to have failed to pay their monthly billed amount only after the conclusion of the required grace period, as described in section 80.2.2.

Nothing in the Act or in this guidance prohibits Part D sponsors from billing an individual for an outstanding amount owed. Sponsors must continue to bill amounts owed under the program in monthly amounts not to exceed the maximum monthly cap according to the statutory formula for the duration of the plan year after an individual has been terminated. The Part D sponsor may also offer the participant the option to repay the full outstanding amount in a lump sum but may not require full immediate repayment. If terminated from the program, the individual must resume paying OOP cost sharing to the pharmacy for any covered Part D drugs subsequently dispensed up to the annual OOP threshold.

### 80.2.1 Notice Requirement

If a Part D sponsor determines that a Medicare Prescription Payment Plan participant has failed to pay a monthly billed amount, the Part D sponsor must send the individual:

- An initial notice explaining that the individual has failed to pay the billed amount within 15 calendar days of the payment due date. The notice must, at minimum:
  - Advise the individual that the Medicare Prescription Payment Plan balance is delinquent;
  - Explain that the Part D sponsor will terminate the individual's program participation if the individual fails to pay the balance within the grace period, as described in section 80.2.2, and identify the date on which the Part D sponsor will terminate the individual's Payment Plan participation if payment is not made;
  - Explain that, if terminated, the individual still owes the amount due under the Medicare Prescription Payment Plan;
  - Explain how to pay the amount due in an expeditious manner;
  - Explain how, if terminated, the individual will pay future OOP cost sharing (i.e., directly to the pharmacy), and, if applicable, will not be permitted to opt into the Medicare Prescription Payment Plan in subsequent years if they remain in the plan without paying the overdue balance;
  - Explain that any potential termination would be only for the Medicare Prescription Payment Plan and would not affect the individual's Part D plan enrollment;
  - Describe the dispute processes available if the individual disputes that they failed to pay the billed amount in a timely manner;
  - Provide general information about applying for the LIS program and how to enroll; and
  - Provide plan contact information for participant questions.
  
- A termination notice explaining that the individual has been terminated from the Medicare Prescription Payment Plan if the individual has failed to pay the amount due by the end of the grace period (see below). This notice must be sent within 3 days after the end of the grace period. The notice must, at minimum:
  - Advise the individual that the Part D sponsor has terminated their Medicare Prescription Payment Plan participation;
  - Explain that the individual will have to pay any OOP cost sharing to the pharmacy for any covered Part D drugs subsequently dispensed up to the annual OOP threshold;
  - Make clear that the individual has not been and will not be disenrolled from the Part D plan;
  - Explain how the Part D sponsor intends to collect any outstanding Medicare Prescription Payment Plan balance from the individual and that the individual may be precluded from opting-in to the program in subsequent years if they do not pay the outstanding balance;
  - Describe the dispute processes available if the individual disputes that they failed to pay the billed amount; and

- Provide plan contact information for participant questions.

If either notice is returned to the Part D sponsor as undeliverable, the Part D sponsor should immediately implement its existing procedure for researching a potential change of address. CMS welcomes feedback on what template communication materials may be required for this purpose.

### *80.2.2 Required Grace Period and Reinstatement*

The Part D sponsor must provide individuals with a grace period of at least 2 months when an individual has failed to pay the billed amount by the payment due date. The grace period must begin on the first day of the month for which the balance is unpaid or the first day of the month following the date on which the payment is requested, whichever is later. Individuals must be allowed to pay the overdue balance during the grace period to remain in the program.

Part D sponsors must also reinstate an individual who has been terminated from the Medicare Prescription Payment Plan if the individual demonstrates good cause for failure to pay the program billed amount within the grace period and pays all overdue amounts billed. To demonstrate good cause, the individual must establish by a credible statement that failure to pay the monthly amount billed within the grace period was due to circumstances for which the individual had no control, or which the individual could not reasonably have been expected to foresee.

Part D sponsors may also reinstate at the sponsor's discretion an individual who has been terminated from the Medicare Prescription Payment Plan if the individual pays all overdue amounts billed, even if the individual does not demonstrate good cause.

### 80.3 Preclusion of Election in a Subsequent Plan Year

Under section 1860D-2(b)(2)(E)(v)(IV)(bb) of the Act, Part D sponsors may preclude an individual from opting into the Medicare Prescription Payment Plan in a subsequent year if the individual fails to pay the amount billed for a month as required under the program.

A Part D sponsor may only preclude an individual from opting into the Medicare Prescription Payment Plan in a subsequent year if the individual owes an overdue balance to that Part D sponsor. If an individual pays off the outstanding balance during the subsequent year the Part D sponsor must permit them to opt in after that point.

A Part D sponsor that offers more than one Part D plan may have different preclusion policies for its different plans. However, it must apply the same policy to every participant in the same plan.

#### 80.4 Prohibition on Part D Plan Enrollment Penalties for Failure to Pay Medicare Prescription Payment Plan Amount Billed

Consistent with section 1860D-1(b)(1)(B) of the Act and 42 CFR § 423.44(b), Part D sponsors may only involuntarily disenroll a Part D enrollee from a Part D plan if the Part D enrollee fails to pay any monthly premium in a timely manner or if CMS grants a disenrollment request when a Part D enrollee engages in disruptive behavior that substantially impairs the Part D sponsor's ability to arrange or provide for services to the individual or to other plan enrollees. A Part D plan sponsor is prohibited from disenrolling a Part D enrollee from a Part D plan for failure to pay any amount billed under the Medicare Prescription Payment Plan.

In addition, a Part D sponsor cannot decline future enrollment into a Part D plan based on an individual's failure to pay a monthly amount billed under the Medicare Prescription Payment Plan.

#### 80.5 Disenrollment

If a participant in the Medicare Prescription Payment Plan is disenrolled voluntarily or involuntarily from their Part D plan under the provisions at 42 CFR § 423.44(b), the participant is also terminated from the Medicare Prescription Payment Plan in that plan. If they enroll in a different plan, they may opt-in to the Medicare Prescription Payment Plan under their new plan. Nothing in the Act or in this guidance prohibits Part D sponsors from billing an individual for an outstanding Medicare Prescription Payment Plan amount owed.

### **90. Participant Disputes**

Consistent with section 1860D-4(h) of the Act and 42 CFR § 423.562, each Part D sponsor must have appeals procedures for making timely coverage determinations regarding the prescription drug benefits an individual is entitled to under the Part D plan. Part D sponsors must apply their established Part D appeals procedures to any dispute made by a Medicare Prescription Payment Plan participant about the amount of Part D cost sharing owed by that participant for a covered Part D drug.

Consistent with section 1860D-4(f) of the Act and 42 CFR § 423.562, each Part D sponsor must provide meaningful procedures for the timely hearing and resolution of grievances between Part D enrollees and Part D sponsors or any entity or individual through which the Part D sponsor provides covered benefits. Part D sponsors must apply their established Part D grievance procedures to any dispute made by a Medicare Prescription Payment Plan participant related to any aspect of the Medicare Prescription Payment Plan, including election requests, billing requirements, and termination-related issues other than disputes related to the amount of Part D cost sharing owed by that participant for a drug.

Please refer to section 30 of the latest Parts C & D Enrollee Grievances, Organization/Coverage Determinations, and Appeals Guidance for details on grievance process requirements and section

40 for details on appeals requirements.<sup>17</sup> CMS requests public comments on whether sections 30 and 40 should be further amended to accommodate this new program.

## 100. Data Submission Requirements

42 CFR § 423.514(a) requires each Part D sponsor to have a procedure to develop, compile, evaluate, and report to CMS, its Part D enrollees, and the public, at the times and in the manner that CMS requires, statistics indicating the following:

- 1) The cost of its operations.
- 2) The patterns of utilization of its services.
- 3) The availability, accessibility, and acceptability of its services.
- 4) Information demonstrating that the Part D sponsor has a fiscally sound operation.
- 5) Pharmacy performance measures.
- 6) Other matters that CMS may require.

To that end, CMS will require Part D sponsors to report information related to the Medicare Prescription Payment Plan on Prescription Drug Event (PDE) records and through new annual reporting requirements.

As described in section 50.1 of this guidance, there should be no impact to PDE cost/payment field reporting, meaning PDE financials should reflect individual and plan liability amounts as if the Medicare Prescription Payment Plan did not apply. Additional guidance on PDE reporting will be forthcoming.

For monitoring purposes, Part D sponsors will also be responsible for reporting data elements related to their Medicare Prescription Payment Plan, both at the beneficiary-level and contract-Plan Benefit Package (PBP) levels. Part D sponsors will report this data on an annual basis. Data files are to be uploaded through HPMS at the contract level, following the availability of templates provided in HPMS. For 2025, CMS does not plan to require independent data validation for these new reporting requirements.

The data elements will be formally proposed for public comment in the **Federal Register** and approved through the Office of Management and Budget (OMB) Paperwork Reduction Act (PRA) process. Once approved, specific guidance will be forthcoming in the CY 2025 Part D Reporting Requirements and Technical Specifications (CMS-10185; OMB 0938-0992), anticipated to be released in Fall 2024.

Proposed data elements for the Medicare Prescription Payment Plan may include, but are not limited to:

### Beneficiary-level Data Elements:

- 1) Contract Number
- 2) PBP Number

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<sup>17</sup> <https://www.cms.gov/medicare/appeals-and-grievances/medprescriptdrugapplgriev>

- 3) Medicare Beneficiary Identifier (MBI) Number
- 4) Beneficiary first name
- 5) Beneficiary last name
- 6) Beneficiary date of birth (DOB)
- 7) Date of election into the Medicare Prescription Payment Plan
- 8) Date of election termination from the Medicare Prescription Payment Plan
- 9) Election termination reason code (voluntary versus involuntary)
- 10) Medicare Prescription Payment Plan amount paid (for each month enrolled)
- 11) Did the Part D sponsor identify the participant as likely to benefit based on POS notification criteria?
- 12) Date Part D sponsor first identified participant as likely to benefit based on POS notification criteria

Contract-PBP-level Data Elements:

- 1) Contract Number
- 2) PBP Number
- 3) Total number of individuals identified as likely to benefit based on POS criteria (unique beneficiaries, including those who did not elect the Medicare Prescription Payment Plan)
- 4) Total uncollected Medicare Prescription Payment Plan balances
- 5) Number of program participants with uncollected Medicare Prescription Payment Plan balances
- 6) Number of individuals precluded from opting into the Medicare Prescription Payment Plan (in subsequent years)

CMS will provide more information about data collection requirements through the PRA process and invite feedback on the proposed elements through the requisite public comment periods.

## **Appendix A – Definitions for Medicare Prescription Payment Plan**

CMS intends to adopt the following definitions for the purposes of this guidance and seeks comments regarding these definitions:

***Covered Part D Drug*** has the meaning set forth at 42 CFR § 423.100.

***Supplemental Drug***: A drug that would be a covered Part D drug, but which is specifically excluded under 42 CFR § 423.100.

***Annual OOP Threshold***: The annual OOP cost threshold is \$2,000 for 2025. For subsequent years, the annual OOP threshold will be calculated in accordance with section 1860D–2(b)(4)(B)(i)(VIII).

***Billing Period***: The calendar month, or the portion of a calendar month, in which OOP costs were incurred, beginning either on the effective date of a Part D enrollee’s participation in the Medicare Prescription Payment Plan (for the first month a participant elects into the program

during the plan year) or the first day of the month (for each subsequent month or for the first month of a participant who elects into the program prior to the start of the plan year), and ending on the last date of that month.

***Incurred Costs (as used in the description of the first month's maximum cap calculation):***

Incurred costs has the meaning set forth at section 1860D-2(b)(4)(C). For the first month's maximum cap calculation of the Part D cost sharing incurred by the Part D enrollee within the plan year, it includes those Part D cost sharing amounts that are incurred prior to effectuation of an election into the Medicare Prescription Payment Plan, including all TrOOP-eligible costs, regardless of payer. If election into the program occurs mid-month, this would include Part D costs incurred within the calendar month of election but prior to election.

***Number of Months Remaining in the Plan Year:*** The count of calendar months remaining in the plan year, including the current reference month (e.g., for a calendar year plan, the months remaining in the calculation for the January maximum cap would be 12).

***OOP Costs:*** Out-of-pocket costs has the same meaning as patient pay amount. For the subsequent month calculation of the Part D cost sharing incurred by the Part D enrollee, it includes those Part D cost sharing amounts that the enrollee is responsible for paying after taking into account amounts paid by third-party payers. Specifically, this does not include the covered plan pay amount or other TrOOP-eligible amount(s), such as any amount paid by potential third-party payers, such as State Pharmaceutical Assistance Programs or charities.

***Remaining OOP Costs Owed by the Participant:*** In subsequent months in which the participant is active in the Medicare Prescription Payment Plan, the remaining OOP costs owed by the participant are the sum of OOP costs incurred under the Medicare Prescription Payment Plan, but not yet billed to the program participant. For example, if a Medicare Prescription Payment Plan participant incurs \$2,000 in January and is billed \$166.67, the remaining OOP costs are  $\$2,000 - \$166.67 = \$1,833.33$ .

***Patient Pay Amount:*** The Patient Pay Amount is the amount paid by the Part D enrollee directly. (e.g., copayments, coinsurance, deductible, or other patient pay amounts). It excludes amounts paid by other parties on behalf of the Part D enrollee.

***TrOOP Accumulator:*** The TrOOP Accumulator is a value Part D sponsors maintain in real time in order to adjudicate a Part D enrollee's claim in the correct benefit phase. The TrOOP Accumulator is the sum of the enrollee's incurred costs for the benefit year known immediately before the Part D sponsor begins adjudication of an individual claim.

## Appendix B – Additional Medicare Prescription Payment Plan Calculation Examples

### *Example B1: January Election with ADAP*

Calculation of Maximum Monthly Cap in First Month: This example demonstrates how the maximum monthly cap would be calculated for a participant with additional prescription drug coverage through an ADAP. The individual has already opted into the Medicare Prescription Payment Plan. The participant presents to the pharmacy in January to fill two prescriptions. The first prescription processed has Part D enrollee cost sharing of \$1,390.28 and is included on the ADAP formulary. The second prescription has Part D enrollee cost sharing of \$665.46 and is not included on the ADAP formulary. After following standard COB processes, the participant's OOP cost sharing for the ADAP-covered drug is reduced to \$0. The final OOP cost sharing for the second drug, which is not covered by ADAP, would be \$609.72 (capped by the annual OOP threshold of \$2,000;  $\$2,000 - \$1,390.28 = \$609.72$ ).

Step 1: Determine the previously incurred costs. The participant has had no prior pharmacy expenditures in January 2025; the TrOOP Accumulator is \$0.

Step 2: Calculate the maximum monthly cap for the first month in which the Medicare Prescription Payment Plan is effective for the participant. The annual OOP threshold for 2025 is \$2,000. The month is January; months remaining in the plan year equals 12 (includes January).

$$(\$2,000 - \$0)/12 = \$166.67$$

The plan will bill \$166.67 for January, since the OOP incurred amount of \$609.72 is higher than the cap.

Calculation of Maximum Monthly Cap in Subsequent Months: In February 2025, the participant refills their existing prescriptions.

Step 1: Determine the remaining costs owed by the participant. Under the Medicare Prescription Payment Plan, the participant incurred \$609.72 in January and was billed \$166.67.

$$\$609.72 - \$166.67 = \$443.05$$

Step 2: Determine the additional OOP costs incurred by the participant. The participant has already reached the annual OOP threshold of \$2,000, so they incur no new OOP costs at this visit. Additional OOP costs incurred = \$0

Step 3: Calculate the maximum monthly cap for the subsequent month. The month is February; months remaining in the plan year equals 11 (includes February).

$$(\$443.05 + \$0)/11 = \$40.28$$

Because the participant in Example B1 has already met the annual OOP threshold (which includes the payments made by the ADAP on behalf of the participant), they will incur no new additional OOP costs. Their maximum monthly cap would be approximately \$40.28 for all months remaining in the plan year, as shown below.

Month	OOP Costs Incurred	Maximum Monthly Cap	Monthly Participant Payment
January	\$609.72	\$166.67	\$166.67
February	\$0	\$40.28	\$40.28
March	\$0	\$40.28	\$40.28
April	\$0	\$40.28	\$40.28
May	\$0	\$40.28	\$40.28
June	\$0	\$40.28	\$40.28
July	\$0	\$40.28	\$40.28
August	\$0	\$40.27	\$40.27
September	\$0	\$40.28	\$40.28
October	\$0	\$40.27	\$40.27
November	\$0	\$40.28	\$40.28
December	\$0	\$40.27	\$40.27
<b>TOTAL</b>	<b>\$609.72</b>		<b>\$609.72</b>

***Example B2: March Election with Supplemental Drugs***

Calculation of Maximum Monthly Cap in First Month: This example demonstrates how the maximum monthly cap would be calculated for a participant in an enhanced alternative plan who is also filling prescriptions for supplemental drugs. The individual opts into the Medicare Prescription Payment Plan at the beginning of March. They have no additional prescription drug coverage through a third party. In January, prior to opting into the program, they filled a single 90-day prescription for a Part D covered drug with a co-pay of \$55. In March 2025, the participant fills two prescriptions, one of which is a supplemental drug. According to the plan’s benefit design, the Part D covered drug has a \$99 copay; the supplemental drug has a \$47 copay. The total OOP cost sharing is \$146; however, because supplemental drugs are not included in the Medicare Prescription Payment Plan, the participant would be responsible for the \$47 copay to the pharmacy. The costs for the \$99 copay would be billed through the normal plan processes for the Medicare Prescription Payment Plan.

Step 1: Determine the previously incurred costs. The individual filled a 90-day supply in January; the TrOOP Accumulator is \$55.00.

Step 2: Calculate the maximum monthly cap for the first month in which the Medicare Prescription Payment Plan election is effective for the participant. The annual OOP threshold for 2025 is \$2,000. The month is March; months remaining in the plan year equals 10 (includes March).

$$(\$2,000 - \$55)/10 = \$194.50$$

The plan will bill \$99.00 for March, since the OOP incurred amount is lower than the cap.

Calculation of Maximum Monthly Cap in Subsequent Months: The participant refills their existing prescriptions in April 2025, including the 90-day prescription previously filled in January.

Step 1: Determine the remaining costs owed by the participant. Under the Medicare Prescription Payment Plan, the participant incurred \$99 in March and was billed \$99.

$$\$99 - \$99 = \$0$$

Step 2: Determine the additional OOP costs incurred by the participant. The participant refills their 90-day maintenance drug (\$55 copay) and refills the \$99 drug and the \$47 supplemental drug. Additional OOP costs incurred (which do not include the supplemental drug):  $\$99 + \$55 = \$154$

Step 3: Calculate the maximum monthly cap for the subsequent month. The month is April; months remaining in the plan year equals 9 (includes April).

$$(\$0 + \$154) / 9 = \$17.11$$

If the participant in Example B2 continued to have the same recurring OOP prescription costs for the remainder of the year (\$99 copay each month and \$55 every third month), their maximum monthly cap would update each month, as shown below.

Month	OOP Costs Incurred	Maximum Monthly Cap	Monthly Participant Payment
January	\$55.00	N/A	\$55.00*
February	\$0.00	N/A	\$0.00
March	\$99.00	\$194.50	\$99.00
April	\$154.00	\$17.11	\$17.11
May	\$99.00	\$29.49	\$29.49
June	\$99.00	\$43.63	\$43.63
July	\$154.00	\$69.30	\$69.30
August	\$99.00	\$89.09	\$89.09
September	\$99.00	\$113.85	\$113.85
October	\$154.00	\$165.18	\$165.18
November	\$99.00	\$214.68	\$214.68
December	\$99.00	\$313.67	\$313.67
<b>TOTAL</b>	<b>\$1,210.00</b>		<b>\$1,210.00</b>

\*This payment was made directly to the pharmacy, outside of the Medicare Prescription Payment Plan.

### ***Example B3: August Election with Part B and D Drugs***

Calculation of Maximum Monthly Cap in First Month: This example demonstrates how the maximum monthly cap would be calculated for a participant who is filling both Part B- and Part D-covered drugs. They have already opted into the Medicare Prescription Payment Plan. The participant has no additional prescription drug coverage through a third party. They present to the pharmacy in August 2025 with two new prescriptions – one for a Part B-covered drug and one for a Part D-covered drug. They have previously filled multiple Part D-covered drugs with a total incurred cost of \$234.63. According to the plan’s benefit design, the OOP cost sharing for the Part D-covered drug would be \$846.68. The cost sharing for the Part B-covered drug would be \$354.77. Because Part B-covered drugs are not included in the Medicare Prescription Payment Plan, the participant would be responsible for the \$354.77 coinsurance to the pharmacy; the \$846.68 would be billed through the normal plan processes for the Medicare Prescription Payment Plan.

Step 1: Determine the previously incurred costs. The individual has previously filled multiple Part D-covered drugs; the TrOOP Accumulator is \$234.63.

Step 2: Calculate the maximum monthly cap for the first month in which the Medicare Prescription Payment Plan election is effective for the participant. The annual OOP threshold for 2025 is \$2,000. The month is August; months remaining in the plan year equals 5 (includes August).

$$(\$2,000 - \$234.63)/5 = \$353.07$$

The plan will bill \$353.07 for August, since the OOP incurred amount of \$846.68 is higher than the cap.

Calculation of Maximum Monthly Cap in Subsequent Months: In September 2025, the participant refills their existing prescriptions.

Step 1: Determine the remaining costs owed by the participant. Under the Medicare Prescription Payment Plan, the participant incurred \$846.68 in August and was billed \$353.07.

$$\$846.68 - \$353.07 = \$493.61$$

Step 2: Determine the additional OOP costs incurred by the participant. The participant refills their multiple maintenance drugs (\$64.02) and both the new Part D- and Part B-covered drugs (\$846.68 and \$354.77, respectively). Additional OOP costs incurred (which do not include the Part B-covered drug):  $\$64.02 + \$846.68 = \$910.70$

Step 3: Calculate the maximum monthly cap for the subsequent month. The month is September; months remaining in the plan year equals 4 (includes September).

$$(\$493.61 + \$910.70)/4 = \$351.08$$

If the participant in Example B3 refills their Part D-covered drugs in October, they would reach the annual OOP threshold of \$2,000 at that time. Their maximum monthly cap for October would change to \$353.74, as shown below, and would remain at that amount for the rest of the year.

Month	OOP Costs Incurred	Maximum Monthly Cap	Monthly Participant Payment
January	\$100.00	N/A	\$100.00*
February	\$34.63	N/A	\$34.63*
March	\$0	N/A	\$0
April	\$100.00	N/A	\$100.00*
May	\$0	N/A	\$0
June	\$0	N/A	\$0
July	\$0	N/A	\$0
August	\$846.68	\$353.07	\$353.07
September	\$910.70	\$351.08	\$351.08
October	\$7.99	\$353.74	\$353.74
November	\$0	\$353.74	\$353.74
December	\$0	\$353.74	\$353.74
<b>TOTAL</b>	<b>\$2,000.00</b>		<b>\$2,000.00</b>

\*These payments were made directly to the pharmacy, outside of the Medicare Prescription Payment Plan.

#### ***Example B4: January Election Mid-Month***

Calculation of Maximum Monthly Cap in First Month: This example demonstrates how to calculate the maximum monthly cap for an individual who opts into the Medicare Prescription Payment Plan mid-month and had incurred costs earlier in the month, prior to opting into the program. The individual presents to the pharmacy in mid-January 2025 to fill a prescription for a new, high-cost drug. They have no additional prescription drug coverage through a third party. The OOP cost sharing is \$1,157.63. Earlier in January, prior to opting into the Medicare Prescription Payment Plan, the individual filled two prescriptions with a total incurred cost of \$57.

Step 1: Determine the previously incurred costs. The individual filled two prescriptions in early January; the TrOOP Accumulator is \$57.00.

Step 2: Calculate the maximum monthly cap for the first month in which the Medicare Prescription Payment Plan election is effective for the participant. The annual OOP threshold for 2025 is \$2,000. The month is January; months remaining in the plan year equals 12 (includes January).

$$(\$2,000 - \$57)/12 = \$161.92$$

The plan will bill \$161.92 for January, since the OOP incurred amount of \$1,157.63 is higher than the cap.

Calculation of Maximum Monthly Cap in Subsequent Months: The participant refills all three of their prescriptions in the month of February.

Step 1: Determine the remaining costs owed by the participant. The participant incurred \$1,157.63 in January (while in the Medicare Prescription Payment Plan) and was billed \$161.92.

$$\$1,157.63 - \$161.92 = \$995.71$$

Step 2: Determine the additional OOP costs incurred by the participant. The participant refills all three prescriptions in February and reaches the annual OOP threshold of \$2,000. Additional OOP costs incurred = \$785.37.

Step 3: Calculate the maximum monthly cap for the subsequent month. The month is February; months remaining in the plan year equals 11 (includes February).

$$(\$995.71 + \$785.37)/11 = \$161.92$$

Because the participant in Example B4 has already met the annual OOP threshold, they will incur no additional OOP costs. Their maximum monthly cap would be approximately \$161.92 for all months remaining in the plan year, as shown below.

<b>Month</b>	<b>OOP Costs Incurred</b>	<b>Maximum Monthly Cap</b>	<b>Monthly Participant Payment</b>
January	\$1,214.63*	\$161.92	\$161.92
February	\$785.37	\$161.92	\$161.92
March	\$0	\$161.92	\$161.92
April	\$0	\$161.92	\$161.92
May	\$0	\$161.92	\$161.92
June	\$0	\$161.91	\$161.91
July	\$0	\$161.92	\$161.92
August	\$0	\$161.91	\$161.91
September	\$0	\$161.92	\$161.92
October	\$0	\$161.91	\$161.91
November	\$0	\$161.92	\$161.92
December	\$0	\$161.91	\$161.91
<b>TOTAL</b>	<b>\$2,000.00</b>		<b>\$2,000.00</b>

\*This amount reflects the total OOP costs incurred in January (\$57 prior to opting into the Medicare Prescription Payment Plan and \$1,157.63 after opting into the Medicare Prescription Payment Plan). The calculation for the first month maximum cap includes the costs incurred prior to the Medicare Prescription Payment Plan election (\$57).

### ***Example B5: January Election with Drug Discontinuation***

Calculation of Maximum Monthly Cap in First Month: This example demonstrates how the maximum monthly cap would be calculated for a participant who fills a prescription for a high-cost drug and then subsequently discontinues it. They have already opted into the Medicare Prescription Payment Plan, anticipating that they would fill multiple months of a high-cost drug. The participant has no additional prescription drug coverage through a third party. The participant presents to the pharmacy in January 2025 to fill their prescription; the OOP cost sharing for the first month is \$642.39.

Step 1: Determine the previously incurred costs. The participant has had no prior pharmacy expenditures in January 2025; the TrOOP Accumulator is \$0.

Step 2: Calculate the maximum monthly cap for the first month in which the Medicare Prescription Payment Plan election is effective for the participant. The annual OOP threshold for 2025 is \$2,000. The month is January; months remaining in the plan year equals 12 (includes January).

$$(\$2,000 - \$0)/12 = \$166.67$$

The plan will bill \$166.67 for January, since the OOP incurred amount of \$642.39 is higher than the cap.

Calculation of Maximum Monthly Cap in Subsequent Months: The participant has an adverse reaction to the drug started in January, and their provider discontinues the drug. They have no prescription claims in February.

Step 1: Determine the remaining costs owed by the participant. The participant incurred \$642.39 in January and was billed \$166.67.

$$\$642.39 - \$166.67 = \$475.72$$

Step 2: Determine the additional OOP costs incurred by the participant. The participant has no new prescription claims in February. Additional OOP costs incurred = \$0.

Step 3: Calculate the maximum monthly cap for the subsequent month. The month is February; months remaining in the plan year equals 11 (includes February).

$$(\$475.72 + \$0)/11 = \$43.25$$

Even though the participant's high-cost prescription has been discontinued, they will continue to receive monthly bills from the Part D sponsor related to their January fill. If the participant in Example B5 continued to have no new covered Part D prescription drug costs, their maximum monthly cap would be approximately \$43.25 for all the months remaining in the plan year, as shown below.

<b>Month</b>	<b>OOP Costs Incurred</b>	<b>Maximum Monthly Cap</b>	<b>Monthly Participant Payment</b>
January	\$642.39	\$166.67	\$166.67
February	\$0.00	\$43.25	\$43.25
March	\$0.00	\$43.25	\$43.25
April	\$0.00	\$43.25	\$43.25
May	\$0.00	\$43.25	\$43.25
June	\$0.00	\$43.25	\$43.25
July	\$0.00	\$43.25	\$43.25
August	\$0.00	\$43.24	\$43.24
September	\$0.00	\$43.25	\$43.25
October	\$0.00	\$43.24	\$43.24
November	\$0.00	\$43.25	\$43.25
December	\$0.00	\$43.24	\$43.24
<b>TOTAL</b>	<b>\$642.39</b>		<b>\$642.39</b>

***Example B6: January Election with Mid-Year Plan Switch***

Calculation of Maximum Monthly Cap in First Month: This example demonstrates how the maximum monthly cap would be calculated for a participant who initially opts into the Medicare Prescription Payment Plan in January under his original plan (Plan A), then switches to a new plan (Plan B) in March. The participant has already elected into the Medicare Prescription Payment Plan for Plan A prior to filling any prescriptions. The participant has no additional prescription drug coverage through a third party. In mid-January, the participant fills three prescriptions, with a total OOP cost sharing of \$498.80.

Step 1: Determine the previously incurred costs. The participant has had no prior pharmacy expenditures in January 2025; the TrOOP Accumulator is \$0.

Step 2: Calculate the maximum monthly cap for the first month in which the Medicare Prescription Payment Plan election is effective for the participant. The annual OOP threshold for 2025 is \$2,000. The month is January; months remaining in the plan year equals 12 (includes January).

$$(\$2,000 - \$0)/12 = \$166.67$$

The plan will bill \$166.67 for January, since the OOP incurred amount of \$498.80 is higher than the cap.

Calculation of Maximum Monthly Cap in Subsequent Months: The participant refills all three of their existing prescriptions in February; the total OOP cost sharing is \$498.80.

Step 1: Determine the remaining costs owed by the participant. The participant incurred \$498.80 in January and was billed \$166.67.

$$\$498.80 - \$166.67 = \$332.13$$

Step 2: Determine the additional OOP costs incurred by the participant. The participant refills all three prescriptions from January; the total OOP cost sharing is \$498.80. Additional OOP costs incurred = \$498.80.

Step 3: Calculate the maximum monthly cap for the subsequent month. The month is February; months remaining in the plan year equals 11 (includes February).

$$(\$332.13 + \$498.80)/11 = \$75.54$$

If the participant in Example B6 switches from their original Part D plan (Plan A) to a new Part D plan (Plan B) in March, they would need to opt into the Medicare Prescription Payment Plan again if they intend to continue spreading their new OOP prescription drug costs over the remainder of the plan year. The maximum monthly cap for their initial month enrolled with Plan B (March) would again use the calculation for the maximum monthly cap in the first month ((Annual OOP Threshold – Incurred Costs)/Number of Months Remaining in the Plan Year). Following the steps outlined above, the participant’s maximum monthly cap for the first month with Plan B would be \$100.24 ((\$2,000 - \$997.60)/10).

Assuming the participant continues to refill their existing prescriptions with a monthly total OOP cost sharing of \$498.80, they would reach the annual OOP threshold of \$2,000 in May.

Month	OOP Costs Incurred (Plan A)	Maximum Monthly Cap (Plan A)	Monthly Participant Payment (Plan A)*	OOP Costs Incurred (Plan B)	Maximum Monthly Cap (Plan B)	Monthly Participant Payment (Plan B)
January	\$498.80	\$166.67	\$166.67	N/A	N/A	N/A
February	\$498.80	\$75.54	\$75.54	N/A	N/A	N/A
March	N/A	N/A	\$75.54	\$498.80	\$100.24	\$100.24
April	N/A	N/A	\$75.54	\$498.80	\$99.71	\$99.71
May	N/A	N/A	\$75.54	\$4.80	\$100.31	\$100.31
June	N/A	N/A	\$75.54	\$0	\$100.31	\$100.31
July	N/A	N/A	\$75.54	\$0	\$100.31	\$100.31
August	N/A	N/A	\$75.54	\$0	\$100.30	\$100.30
September	N/A	N/A	\$75.54	\$0	\$100.31	\$100.31
October	N/A	N/A	\$75.54	\$0	\$100.30	\$100.30
November	N/A	N/A	\$75.54	\$0	\$100.31	\$100.31
December	N/A	N/A	\$75.53	\$0	\$100.30	\$100.30
<b>TOTAL</b>	<b>\$997.60</b>		<b>\$997.60</b>	<b>\$1,002.40</b>		<b>\$1,002.40</b>

\*This example assumes the participant does not pay off the remaining balance to Plan A in a single lump sum and continues to receive monthly bills from Plan A.

### ***Example B7: January Election with LIS***

Calculation of Maximum Monthly Cap in First Month: This example demonstrates how the maximum monthly cap would be calculated for a participant who receives a LIS. They have already opted into the Medicare Prescription Payment Plan. The participant is LIS-eligible (category code 1) and has no additional prescription drug coverage through a third party. The participant presents to the pharmacy in January 2025 to fill four generic prescriptions with copays of \$4.50 each<sup>18</sup> (\$18.00 total). Because these are low-cost generic drugs, the individual does not reach the annual OOP threshold in 2025.

Step 1: Determine the previously incurred costs. The participant has had no prior pharmacy expenditures in January 2025; the TrOOP Accumulator is \$0.

Step 2: Calculate the maximum monthly cap for the first month in which the Medicare Prescription Payment Plan election is effective for the participant. The annual OOP threshold for 2025 is \$2,000. The month is January; months remaining in the plan year equals 12 (includes January).

$$(\$2,000 - \$0)/12 = \$166.67$$

The plan will bill \$18.00 for January, since the OOP incurred amount is lower than the cap.

Calculation of Maximum Monthly Cap in Subsequent Months: The participant refills all four of their existing prescriptions in February.

Step 1: Determine the remaining costs owed by the participant. The participant incurred \$18.00 in January and was billed \$18.00.

$$\$18.00 - \$18.00 = \$0$$

Step 2: Determine the additional OOP costs incurred by the participant. The participant refills four prescriptions with copays of \$4.50 each, for a total OOP cost sharing of \$18.00. Additional OOP costs incurred = \$18.00.

Step 3: Calculate the maximum monthly cap for the subsequent month. The month is February; months remaining in the plan year equals 11 (includes February).

$$(\$0 + \$18.00)/11 = \$1.64$$

If the participant in Example B7 remains LIS-eligible and continues to fill their four prescriptions each month through the remainder of the year, their maximum monthly cap would update as shown below.

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<sup>18</sup> Copay amounts subject to change with updated Part D benefit parameters for 2025.

<b>Month</b>	<b>OOP Costs Incurred</b>	<b>Maximum Monthly Cap</b>	<b>Monthly Participant Payment</b>
January	\$18.00	\$166.67	\$18.00
February	\$18.00	\$1.64	\$1.64
March	\$18.00	\$3.44	\$3.44
April	\$18.00	\$5.44	\$5.44
May	\$18.00	\$7.69	\$7.69
June	\$18.00	\$10.26	\$10.26
July	\$18.00	\$13.26	\$13.26
August	\$18.00	\$16.85	\$16.85
September	\$18.00	\$21.36	\$21.36
October	\$18.00	\$27.35	\$27.35
November	\$18.00	\$36.36	\$36.36
December	\$18.00	\$54.35	\$54.35
<b>TOTAL</b>	<b>\$216.00</b>		<b>\$216.00</b>

***Example B8: January Election with Retroactive LIS***

Calculation of Maximum Monthly Cap in First Month: This example demonstrates how the maximum monthly cap would be calculated for an individual who initially opts into Medicare Prescription Payment Plan and incurs OOP costs while in the program, then becomes LIS-eligible in March, with an effective date retroactive to January 1, 2025. The individual initially opts into the Medicare Prescription Payment Plan in early January and has no additional prescription drug coverage through a third party. In January 2025, the participant fills a single prescription for a brand drug; the total OOP cost sharing is \$341.91.

Step 1: Determine the previously incurred costs. The participant has had no prior pharmacy expenditures in January 2025; the TrOOP Accumulator is \$0.

Step 2: Calculate the maximum monthly cap for the first month in which the Medicare Prescription Payment Plan election is effective for the participant. The annual OOP threshold for 2025 is \$2,000. The month is January; months remaining in the plan year equals 12 (includes January).

$$(\$2,000 - \$0)/12 = \$166.67$$

The plan will bill \$166.67 for January, since the OOP incurred amount of \$341.91 is higher than the cap.

Calculation of Maximum Monthly Cap in Subsequent Months: The participant refills their prescription in February.

Step 1: Determine the remaining costs owed by the participant. The participant incurred \$341.91 in January and was billed \$166.67.

$$\$341.91 - \$166.67 = \$175.24$$

Step 2: Determine the additional OOP costs incurred by the participant. The participant refills their prescription in February; the OOP cost sharing is \$341.91. Additional OOP costs incurred = \$341.91.

Step 3: Calculate the maximum monthly cap for the subsequent month. The month is February; months remaining in the plan year equals 11 (includes February).

$$(\$175.24 + \$341.91)/11 = \$47.01$$

If the participant in Example B8 becomes LIS-eligible in early March, with an effective date retroactive to January 1, 2025, their claims from January and February will need to be reprocessed. The amount the participant has already paid the Part D plan while in the Medicare Prescription Payment Plan will need to be reconciled with the revised OOP cost sharing amounts (see section 70.3.6 of this guidance for additional information).

The participant in Example B8 is now LIS-eligible (category code 2). If they remain LIS-eligible and continue to fill their single prescription (now with a cost share of \$4.60<sup>19</sup>) through the remainder of the year, their maximum monthly cap will update as shown below. Because payments by the LIS program count toward the individual's TrOOP, they would reach the annual OOP threshold in June.

Month	OOP Costs Incurred	Maximum Monthly Cap	Monthly Participant Payment
January	<i>(\$341.91)</i> \$4.60*	\$166.67	<i>(\$166.67)</i> \$4.60*
February	<i>(\$341.91)</i> \$4.60*	<i>(\$47.01)</i> \$0.42*	<i>(\$47.01)</i> \$0.42*
March	\$4.60	\$0.88	\$0.88
April	\$4.60	\$1.39	\$1.39
May	\$4.60	\$1.96	\$1.96
June	\$4.60	\$2.62	\$2.62
July	\$0	\$2.62	\$2.62
August	\$0	\$2.62	\$2.62
September	\$0	\$2.62	\$2.62
October	\$0	\$2.62	\$2.62
November	\$0	\$2.63	\$2.63
December	\$0	\$2.62	\$2.62
<b>TOTAL</b>	<b>\$27.60</b>		<b>\$27.60</b>

\*Values shown in parentheses and italics are the original OOP costs, maximum monthly cap, and monthly participant payments, calculated prior to the participant receiving LIS status. The revised values show how the amounts would be updated, given the individual's LIS eligibility (the maximum monthly cap for the first month (January) did not change).

<sup>19</sup> Copay amounts subject to change with updated Part D benefit parameters for 2025.