MEDPAC | Medicare Payment Advisory Commission

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January 27, 2025

Jeff Wu
Acting Administrator
Centers for Medicare & Medicaid Services
Department of Health and Human Services
P.O. Box 8016
Baltimore, MD 21244-8016

Attention: CMS-4208-P

Dear Mr. Wu:

The Medicare Payment Advisory Commission (MedPAC) welcomes the opportunity to comment on the Centers for Medicare & Medicaid Services (CMS) notice of proposed rulemaking entitled "Medicare and Medicaid Programs; Contract Year 2026 Policy and Technical Changes to the Medicare Advantage Program, Medicare Prescription Drug Benefit Program, Medicare Cost Plan Program, and Programs of All-Inclusive Care for the Elderly," published in the *Federal Register*, vol. 89, no. 237, pages 99340 to 99579. We appreciate your staff's work on the notice, particularly considering the competing demands on the agency.

This proposed rule includes many provisions that would revise regulations for the Medicare Advantage (MA) program (Part C) and the Prescription Drug Benefit program (Part D). Our comments focus on the following provisions:

- Network transparency for pharmacies
- Medicare Advantage supplemental benefits
- Analysis of utilization management policies and procedures
- MA network adequacy: Plan benefit package–level reviews
- Format MA organizations' provider directories for Medicare Plan Finder
- Formulary inclusion and placement of generics and biosimilars

Network transparency for pharmacies

For some beneficiaries, access to their pharmacy of choice is vitally important for ensuring their adherence to medication therapies. During the annual enrollment period, beneficiaries can check the Medicare Plan Finder (MPF) to find out whether a particular pharmacy is in network for a plan of interest, but the MPF does not allow beneficiaries to search for all plans in which a given pharmacy is in network.

As a result, the process of understanding whether certain pharmacies are in network can be cumbersome when choosing between different Part D plans. Because of this, some beneficiaries may unintentionally enroll in (or remain in) a plan that does not include their pharmacy of choice. When searching for a Part D plan, some beneficiaries may rely on their pharmacist to help them determine the plan networks to which their pharmacy belongs. However, pharmacies may not always have the information needed to help such beneficiaries, in part due to the large number of contracting activities pharmacies often engage in with multiple plan sponsors/pharmacy benefit managers (PBMs). As CMS notes in the proposed rule, because plan sponsors typically offer "more than one plan in a service area, sometimes under more than one contract and under more than one marketing name," and because pharmacies often are not able to "demand clear information from PBMs and plans regarding which networks they will participate in," pharmacies may not always know whether they are in network for a given plan.

To help address this issue, CMS proposes to require Part D sponsors (or first tier, downstream, or related entities, such as PBMs, on the sponsors' behalf) to notify network pharmacies as to which plans the pharmacies will be in network for in a given plan year by October 1 of the year prior to that plan year. Plan sponsors would also be required to provide a list of these plans to network pharmacies upon request after October 1.

Comment

The Commission appreciates and supports the agency's aim to allow beneficiaries to more easily obtain accurate information about a pharmacy's participation in a Part D plan's network. This proposal to require plan sponsors to submit to pharmacies a final comprehensive list of all plans for which the pharmacy is in network would enhance pharmacies' ability to provide timely and accurate information to their patients who are eligible to enroll in a Part D plan. At the same time, because MPF is widely used by beneficiaries (or their families), and in many instances, health care providers and counselors (such as State Health Insurance Assistance Programs), to help beneficiaries navigate the complex choice regarding their health benefits, we encourage CMS to continue to explore whether the MPF could be further improved to accommodate searches by participating pharmacies.

Medicare Advantage supplemental benefits

In addition to covering basic Part A and Part B services, MA plans may provide "supplemental" benefits to their enrollees, such as reduced cost sharing for Part A and Part B services, reduced Part B and Part D premiums, enhanced Part D benefits, and other benefits

not covered under fee-for-service Medicare. Since 2021, it has become increasingly common for MA plans to administer supplemental benefits using pre-funded debit cards, sometimes referred to as "over-the-counter (OTC) cards" or "flex cards".[1] Enrollees in such plans can use the plan-provided card to pay for supplemental benefits offered by their plan (plans can define which benefits enrollees can use the cards to pay for).

MA organizations (MAOs) using a debit card to administer supplemental benefits are required to ensure that the card is used to pay only for plan-covered items and services that meet regulatory requirements set out by CMS (particularly those at §§ 422.100, 422.102, and 422.112). In the proposed rule, CMS states that the agency has received complaints from enrollees who have had difficulties using their plan-provided card, owing particularly to confusion about where or how to use the card and about which items can be purchased with the card. In addition, CMS cites "concerns that there are not enough guardrails on how these cards are used and how purchases are tracked, especially at large box stores that carry noncovered items and services (for example, Costco or Walmart)."

To address these concerns, CMS proposes a set of policies that would address how MAOs administer supplemental benefits. Among these are proposals to require that:

- MAOs have processes for ensuring that all covered supplemental benefits are compliant with the applicable regulations,
- debit cards be linked to a real-time electronic verification system to ensure that the cards are used only for covered items,
- plans disclose benefit limitations more clearly to enrollees,
- MAOs provide instructions and customer service support related to plan-provided debit cards, and
- plans have an alternative process that allows for reimbursement of eligible expenses when there are issues with the plan-provided card.

CMS also proposes to codify guidance about the goods and services that can (and cannot) be covered as supplemental benefits, and to tighten the definition of "chronically ill" used to determine eligibility for special supplemental benefits for the chronically ill (SSBCI).

Comment

The Commission appreciates CMS's continued attention to MA supplemental benefits and supports the proposed efforts to improve transparency and appropriateness of supplemental benefits. Medicare's spending on the MA rebates that finance supplemental benefits has increased sharply in recent years and now represents a significant portion of program spending: In 2024, we estimate that Medicare paid MA plans approximately $83 billion (about $2,500 per enrollee) to provide supplemental benefits—up from $21 billion

[1] https://www.medpac.gov/wp-content/uploads/2023/10/MA-supp-benefits-MedPAC-Oct-2024-SEC.pdf

in 2018.[2] In their bids, plans report that they anticipate using about $38 billion of that spending to finance the provision of non-Medicare covered benefits.[3] That spending is used to offer an array of benefits to MA enrollees, such as enhanced financial protection through reduced premiums and cost-sharing liability, and services not covered by Medicare. However, despite Medicare's significant level of spending on rebates for supplemental benefits, the data that the program collects are insufficient for answering many important questions about how supplemental benefits are delivered by plans or used by MA enrollees. For example, we do not know how much plans spend on each type of benefit, which enrollees use each benefit (and how frequently), or whether the goods and services provided as supplemental benefits are consistently compliant with program rules. Without this information, it is difficult to determine whether Medicare's high level of spending on supplemental benefits provides good value to MA enrollees and the taxpayers who fund the program.[4] CMS's justification of the proposed rule, that enrollees in some plans might be using plan-provided debit cards to purchase items that do not meet program criteria, is consistent with MedPAC's concerns that it is hard to assess whether supplemental benefits are being used as intended.[5]

MedPAC and others have found that the share of MA enrollees in plans using "combination benefits," which are often administered using the debit cards addressed in the proposed rule, has increased dramatically since 2021, reaching 45 percent of enrollees in conventional (i.e., non-employer, non-special needs plan (SNP)) plans and 86 percent of enrollees in SNPs in 2024.[6] In addition, the average estimated annualized benefit limit (i.e., the maximum amount the plan will make available on the card to the enrollee per year) has also rapidly increased since 2021. For example, in plans in which enrollees can use a plan-provided card to pay for over-the-counter items or SSBCI, the average annualized benefit limit increased from $447 in 2021 to $1,507 in 2024.[7,8] Common benefits covered under these arrangements include support for purchasing food and produce, and "general supports for living" which can include subsidies for rent and/or subsidies for utilities such as gas, electricity, and water.[9] Due to a general lack of transparency about supplemental benefits in MA, little is known about the extent to which enrollees use these benefits.[10] One trade association examined 2020 data for 30,000 MA enrollees in a regional plan who had access to an over-the-counter (OTC) benefit (in which the plan subsidizes their enrollees'

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[2] https://www.medpac.gov/wp-content/uploads/2023/10/MA-supp-benefits-MedPAC-Oct-2024-SEC.pdf
[3] We estimate that, of the $83 billion paid to MA plans as rebates in 2024, about $8 billion will be used to reduce Part D premiums, about $10 billion will go toward enhanced Part D benefits, nearly $4 billion will be used to reduce Part B premiums, about $24 billion will be used to reduce cost sharing, and $38 billion will be used to provide extra benefits.
[4] https://www.gao.gov/products/gao-23-105527
[5] https://www.ecfr.gov/current/title-42/chapter-IV/subchapter-B/part-422
[6] https://www.medpac.gov/wp-content/uploads/2023/10/MA-supp-benefits-MedPAC-Oct-2024-SEC.pdf
[7] Beginning in 2020, as required by the Bipartisan Budget Act of 2018, MA plans were given the ability to offer non-primarily health related items or services to chronically ill enrollees, so long as there is a "reasonable expectation of improving or maintaining the health or overall function of the chronically ill enrollee." CMS refers to these services as special supplemental benefits for the chronically ill, or SSBCI. In 2024, the most common nonmedical benefits were food and produce, and "general supports for living," which is allowed to include plan-provided housing support, plan-provided housing consultations, subsidies for rent or assisted living communities, and subsidies for utilities. (See https://www.cms.gov/medicare/health-plans/healthplansgeninfo/downloads/supplemental_benefits_chronically_ill_hpms_042419.pdf)
[8] https://www.medpac.gov/wp-content/uploads/2023/10/MA-supp-benefits-MedPAC-Oct-2024-SEC.pdf
[9] https://www.milliman.com/en/insight/2024-combined-benefits-medicare-advantage-tracking-benefit-strategy
[10] https://www.medpac.gov/wp-content/uploads/2024/03/Mar24_Ch12_MedPAC_Report_To_Congress_SEC-1.pdf

purchase of health-related items like bandages or OTC medicines) and found that only 33 percent of eligible beneficiaries used the OTC benefit during the year.[11] For several years, the Commission has expressed concern about the lack of transparency surrounding the delivery and use of supplemental benefits.[12,13,14] Through recent rulemaking, CMS has taken steps to improve transparency by requiring MAOs to report information about the amounts they spend to deliver supplemental benefits and the extent to which their enrollees use the benefits.[15] In addition, CMS has taken steps to improve how supplemental benefits are reported and identified in MA encounter data.[16] MedPAC supports these actions and generally supports efforts to make the MA program more transparent.[17,18] However, even with the proposed rule, the data currently collected by CMS will likely not enable the agency or other entities to monitor whether plan-provided debit cards are being used only for goods and services that meet regulatory criteria.

Analysis of utilization management policies and procedures

CMS currently requires MAOs to submit information about the use of prior authorization and other utilization management activities, aggregated annually at the contract level. This year, CMS proposes to require plans to submit more granular data on prior authorization use, and how it affects different types of beneficiaries. Specifically, MAOs will be required to report the following prior authorization metrics, not only in aggregate, but also by each covered item and service:

- The percentage of standard prior authorization requests that were approved, reported by each covered item and service.
- The percentage of standard prior authorization requests that were denied, reported by each covered item and service.
- The percentage of standard prior authorization requests that were approved after appeal, reported by each covered item and service.
- The percentage of prior authorization requests for which the timeframe for review was extended, and the request was approved, reported by each covered item and service.
- The percentage of expedited prior authorization requests that were approved, reported by each covered item and service.

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[11] https://www.chpa.org/about-consumer-healthcare/research-data/research-reports/using-medicare-advantage-over-counter-otc-consumer-engagement
[12] https://www.medpac.gov/document/march-2022-report-to-the-congress-medicare-payment-policy/
[13] https://www.medpac.gov/wp-content/uploads/2023/10/MA-supp-benefits-MedPAC-Oct-2024-SEC.pdf
[14] https://www.medpac.gov/wp-content/uploads/2024/05/05292024_MedPAC_MA_Data_RFI_comment-letter_SEC.pdf
[15] https://www.medpac.gov/wp-content/uploads/2023/10/MA-supp-benefits-MedPAC-Oct-2024-SEC.pdf
[16] https://www.csscoperations.com/internet/csscw3.nsf/DID/DS4HT48I7K
[17] https://www.medpac.gov/wp-content/uploads/2024/05/05292024_MedPAC_MA_Data_RFI_comment-letter_SEC.pdf
[18] https://www.medpac.gov/wp-content/uploads/2022/03/03042022_MA_PartD_NPRM_CMS4192P_MedPAC_COMMENT_v2_SEC.pdf

- The percentage of expedited prior authorization requests that were denied, reported by each covered item and service.
- The average and median time that elapsed between the submission of a request and a determination by the MA plan, for standard prior authorizations, reported by each covered item and service.
- The average and median time that elapsed between the submission of a request and a decision by the MA plan for expedited prior authorizations, reported by each covered item and service.

In its proposal, CMS acknowledges the concern that increasing the number of reported measures might make it more difficult for enrollees, potential enrollees, and the public to interpret them. Thus, CMS also proposes to require MAOs to submit an executive summary with the data, to facilitate public and enrollee understanding of the results.

Comment

The Commission commends CMS on its efforts to better understand how prior authorization is used in MA at the item and service level and on its continued commitment to monitoring how utilization management practices may affect vulnerable beneficiaries. Further information on utilization management is useful to promote transparency and enable better oversight of the MA program and the performance of MA plans. We encourage CMS to consider requiring MAOs to both publicly report summary statistics that will promote transparency, and to submit to CMS more granular data at the item and service level for oversight purposes.

In both instances, the Commission urges CMS to require MAOs to report rates of prior authorization and related metrics at the *plan* rather than the contract level. The Commission has written at length about our concerns with contract-level reporting.[19, 20, 21, 22] Because beneficiaries enroll in an MA plan rather than a contract, reporting at the plan level would be more informative for policymakers and individuals. Further, plan-level reporting is required for adequate monitoring of practices such as prior authorization, because a contract's average may mask a wide range of plan practices. For instance, while HMOs and PPOs are not permitted to be in the same contract, SNPs are often included in contracts with non-SNPs, and some contracts can include both standard HMO and HMO-Point of Service plans, all of which may have different prior authorization practices. Plan-level reporting would also ensure that new data on prior authorization is consistent with CMS's proposal to assess network adequacy at the plan level (see next section).

The Commission appreciates the agency's concern about publishing this information in amounts and levels of detail that would be unhelpful for beneficiaries and their families.

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[19] https://www.medpac.gov/wp-content/uploads/2024/06/Jun24_Ch2_MedPAC_Report_To_Congress_SEC.pdf
[20] https://www.medpac.gov/wp-content/uploads/2024/03/Mar24_Ch12_MedPAC_Report_To_Congress_SEC-1.pdf
[21] https://www.medpac.gov/document/march-2023-report-to-the-congress-medicare-payment-policy/
[22] https://www.medpac.gov/document/june-2020-report-to-the-congress-medicare-and-the-health-care-delivery/

In lieu of MAOs producing their own executive summaries of this material, however, the Commission encourages CMS to consider publicly reporting a small set of summary measures of particular relevance to beneficiaries. For example, CMS could require each plan to report:

- The percentage of plan enrollees for whom one or more prior authorizations were required in the previous plan year, in aggregate and for different diagnostic categories.
- Among those enrollees who were subject to prior authorization, the average number of authorizations required per enrollee in the previous plan year.
- The share of prior authorizations that were approved, denied, and approved by the plan on appeal, and any differences in approval rates by diagnostic categories.
- The top service categories for which prior authorization is most often requested, approved, and denied by the plan.
- A searchable list of items requiring prior authorization, according to plan coverage policies.
- The number of complaints and grievances received by the plan in the previous plan year, and the share of those related to a prior authorization request.

In addition to the metrics proposed in the rule, CMS should consider granular data collection for program oversight purposes, to include:

- The raw counts of prior authorization requests and their outcomes, in addition to or instead of percentages. This is important to be able to understand the volume of prior authorization requests processed by each plan, in addition to the share of those requests that have certain characteristics.
- A list of all applicable items and services that were subject to a prior authorization requirement under the plan during the previous plan year.
- The number of prior authorization requests approved, partially approved, and denied by the plan in an initial plan determination, upon reconsideration by the plan, and upon appeal to the qualified review entity (both in the aggregate and categorized by each item and service).
- The number of prior authorization requests that were processed using decision support, artificial intelligence, or machine-learning technology, the items and services for which these requests were made, the outcomes of these decisions, and a description of the technology.
- The number of requests that were denied on the basis that they were not submitted with the required medical or other documentation.
- The number of grievances received by each plan during the previous plan year that were related to a prior authorization requirement.

This more granular data will enable better understanding of how plans use prior authorization, for whom, and under what circumstances. To the extent that some beneficiaries (e.g., those with a particular diagnosis, requiring a certain service or product, or living in a specific area) are disproportionately subject to prior authorizations, it will be important to analyze the use of prior authorization to understand whether it contributes to differences in access to care among Medicare beneficiaries. Information on the time that elapses between a prior authorization request and a decision would also provide insight into potential barriers to access that this practice may cause.[23]

We encourage CMS to consider the administrative burden on MAOs to produce executive summaries of these results, relative to their utility for enrollees and the public. A key benefit of this more granular data is that it can inform beneficiaries' decision-making with respect to their own needs. This reporting will be valuable but may be burdensome, and the agency may not want to further add to that burden by requiring these summaries.

MA network adequacy: Plan benefit package-level reviews

CMS currently requires network adequacy reviews for all new MA contracts and service area expansions, and for all contracts on roughly a three-year review cycle thereafter. MA contract networks must meet network adequacy standards in each county in which they operate. In the proposed rule, CMS considers requiring the review of network adequacy for active contracts at the plan benefit package (PBP) level, rather than the county-contract level, as is currently done.

Comment

As discussed above, the Commission has long supported reporting and analyzing MA performance at the plan-county level, rather than the contract level.[24, 25, 26, 27] It is important for beneficiaries to have information about the performance of plans in their local market area when choosing how to receive their Medicare benefits. Because, on the one hand, MA contracts frequently span multiple market areas, and on the other, plans in the same contract in the same market area may not necessarily share a provider network, the current approach of assessing plan's network adequacy at the contract level does not provide meaningful information to beneficiaries about an individual plan's network. For these reasons, reviewing network adequacy at the plan-county level is crucial for enrollees to make informed choices. While the current method of reviewing networks by contract within each county addresses the challenge of geographically disparate contracts, it does not address scenarios in which MAOs offer different networks for different plans under the same contract in the same local area.

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[23] https://www.medpac.gov/wp-content/uploads/2024/05/05292024_MedPAC_MA_Data_RFI_comment-letter_SEC.pdf
[24] https://www.medpac.gov/wp-content/uploads/2024/06/Jun24_Ch2_MedPAC_Report_To_Congress_SEC.pdf
[25] https://www.medpac.gov/wp-content/uploads/2024/03/Mar24_Ch12_MedPAC_Report_To_Congress_SEC-1.pdf
[26] https://www.medpac.gov/document/march-2023-report-to-the-congress-medicare-payment-policy/
[27] https://www.medpac.gov/document/june-2020-report-to-the-congress-medicare-and-the-health-care-delivery/

The Commission recognizes that assessing network adequacy is a challenging exercise, and needs vary by local practice patterns and supply, specialty type, and beneficiary preferences. We encourage CMS to continue to be mindful of how network adequacy standards may or may not reflect provider supply and beneficiary demand for certain services, including behavioral health care, in considering this proposal.

Format MAOs' provider directories for Medicare Plan Finder

Currently, CMS requires MAOs to disclose information to enrollees about a plan's service area and contracted providers in the form of an online provider directory. CMS proposes to require MAOs to submit provider directories so that they will be viewable on the Medicare Plan Finder beginning with the 2026 annual enrollment period. The proposal would also require plans to submit updates within 30 days of network changes, and to attest to the accuracy of this information and its compliance with network adequacy standards.

Comment

The Commission supports CMS's continued efforts to facilitate the maintenance and dissemination of accurate MA provider network information. As we have noted previously, timely and accurate information about the providers included in an MA plan's network is crucial for beneficiaries because it enables them to make informed decisions about, first, enrolling in a plan and, subsequently, seeking health care services. The accuracy of MA provider network information is important not just for beneficiary choice, access to care, and program monitoring; it has cost-sharing implications for beneficiaries.[28, 29]

Making MA provider directories available to beneficiaries and the public through the Medicare Plan Finder would facilitate more informed coverage choices and may encourage more beneficiaries to shop during the annual enrollment period. Requiring timely updates would also enable MA enrollees to understand changes to their plan's network throughout the year.

But the current system for generating and maintaining provider directories—which requires plans to maintain their own directories, and provider groups to submit their information to every plan they contract with—is costly and inefficient. CMS's proposal would help facilitate enrollees' access to network information, but it would not address the administrative burdens on plans and providers. CMS should continue to pursue a solution that would be useful for beneficiaries in their individual decision-making and to policymakers in their oversight of the program while reducing burden on plans and providers.

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[28] https://www.medpac.gov/wp-content/uploads/2024/05/05292024_MedPAC_MA_Data_RFI_comment-letter_SEC.pdf
[29] https://www.medpac.gov/wp-content/uploads/2024/06/Jun24_Ch2_MedPAC_Report_To_Congress_SEC.pdf

Formulary inclusion and placement of generics and biosimilars

Multiple reports and findings have raised concerns that Part D sponsors and their PBMs may structure their formularies to favor more expensive brand-name drugs and reference biological products over lower cost generics and biosimilars.[30] Because of this concern, CMS proposes to include an additional review to determine whether Part D sponsors provide broad access to generics, biosimilars, and other lower cost drugs. The review will assess whether the formulary includes generics, biosimilars, and other lower-cost drugs, when available, for brand-name drugs and reference products, and whether these lower-cost drugs are placed on a lower formulary tier than their brand counterparts. In addition, CMS would review sponsors' use of utilization management tools on lower-cost alternatives compared with those applied to their brand counterparts.

CMS reminds plan sponsors that, in order to be compliant with Part D program requirements, plans must utilize a "cost-effective drug utilization management program, including incentives to reduce costs when medically appropriate, such as through the use of multiple source drugs." As such, CMS expects the additional formulary review to ensure that Part D plans provide access to low-cost drugs, including generics and biosimilars, while applying appropriate and cost-effective utilization management requirement.

Comment

The Commission has consistently supported the agency's efforts to ensure that beneficiaries have access to medically appropriate medications at lower costs.[31] Closer formulary review to assess appropriate coverage of generics and biosimilars may further encourage Part D sponsors and their PBMs to structure their formularies in ways that promote beneficiaries' access to and use of lower-cost drugs.

The Commission recognizes that, at times, the financial incentives of plan sponsors may be at odds with the coverage preferences of beneficiaries and the financial interests of the taxpayers.[32] Simultaneously, because formulary design is one of the key tools used by plan sponsors to manage drug spending and to negotiate rebates with pharmaceutical manufacturers, the Commission has also advocated for plan sponsors to have greater formulary flexibility to effectively manage their enrollees' costs.[33]

We commend CMS for continuing to examine its formulary procedures for opportunities to increase beneficiaries' access to biosimilars and generic drugs while balancing plan

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[30] https://oig.hhs.gov/reports/all/2022/medicare-part-d-and-beneficiaries-could-realize-significant-spending-reductions-with-increased-biosimilar-use, https://www.ftc.gov/system/files/ftc_gov/pdf/pharmacy-benefit-managers-staff-report.pdf
[31] See https://www.medpac.gov/wp-content/uploads/2023/02/02102023_MA_and_Part-D_MedPAC_COMMENT_SEC.pdf.
[32] https://www.medpac.gov/wp-content/uploads/2023/06/Jun23_Ch2_MedPAC_Report_To_Congress_SEC.pdf, https://www.medpac.gov/wp-content/uploads/import_data/scrape_files/docs/default-source/reports/jun20_ch5_reporttocongress_sec.pdf
[33] https://www.medpac.gov/wp-content/uploads/import_data/scrape_files/docs/default-source/comment-letters/01032018_partc_d_comment_v2_sec.pdf, https://www.medpac.gov/wp-content/uploads/import_data/scrape_files/docs/default-source/reports/jun20_ch5_reporttocongress_sec.pdf, https://www.medpac.gov/wp-content/uploads/import_data/scrape_files/docs/default-source/comment-letters/02282014_partd_comment.pdf.

sponsors' need for formulary flexibility to effectively manage enrollees' drug spending by applying this policy as an additional step in the formulary review process.

Conclusion

MedPAC appreciates your consideration of these issues. The Commission values the ongoing collaboration between CMS and MedPAC staff on Medicare policy, and we look forward to continuing this relationship. If you have any questions regarding our comments, please do not hesitate to contact Paul B. Masi, MedPAC's Executive Director, at 202-220-3700.

Sincerely,

Michael E. Chernew, Ph.D.
Chair

MC/krs/th/ss/ sh