

MEMO

DATE: April 15, 2011
TO: Clients & Friends
FROM: John Gorman and Jean LeMasurier
SUBJECT: Memo on Final Rule CMS-4144-F: Changes to the MA PDP Programs for CY 2012

The Centers for Medicare and Medicaid Services (CMS) issued the final rule on changes to the Medicare Advantage and Medicare Prescription Drug Programs for CY 2012 and other changes. A copy of the final rule can be found at: <http://www.gormanhealthgroup.com/docs/cms/CMS4144F.pdf>

Key changes in the Final Rule include:

Cost Sharing Limited to FFS – The final rule deletes the proposal that plans charge \$0 for home health cost sharing and clarifies that other cost sharing only applies to “in-network” services.

NCQA Approval of SNPs – The final rule modifies the proposed rule to only require that NCQA approve the Model of Care and deletes the requirement for NCQA approval of the QI program plan. The process to approve Models of Care (MOCs) will reward SNPs with higher scores with a longer approval period.

Dispensing of Drugs in Long-term Care (LTC) Facilities – Under the final rule pharmacies shall dispense solid oral brand name drugs in 14-day-or-less increments at a time (rather than the no greater than seven-day increments included in the proposed rule). The Final Rule also delays the dispensing and reporting until January 1, 2013 and provides waivers for I/T/U pharmacies.

Complaint Tracking Module – Sponsors can choose a drop down box or text box to report resolutions of complaints.

Uniform Exceptions and Appeals – CMS will modify the current model coverage determination form and develop a new separate notice for redeterminations. The Final Rule deletes the requirements for an interactive web-based system to provide instant access to enrollees to the coverage determination process and allows plans to use a variety of means that at a minimum includes a secure e-mail address.

MTM Programs - Under the final rule, CMS is dropping a proposed requirement that Part D plans must coordinate their MTM programs with the drug regimen reviews performed by LTC consultant pharmacists.

Part D Coverage Gap – The final rule modifies the definitions and excludes vaccine administration fees.

Medicare Advantage Quality Bonus and Rebate Retention Appeals – The final rule changes the appeal process to a two-step administrative review and lengthens the timeframes.

Prohibition Against Owners – The final rule narrows the scope of the prohibition included in the proposed rule.

Medical Review – The final rule narrows the scope of medical review and the professionals who must conduct the review.

Compliance Officer Training – The final rule deletes the requirement for annual compliance officer training.

Call Centers – The final rule deletes a proposed requirement that plans accommodate all languages and instead requires on-site interpreters or contracts that support 150 to 180 languages.

Part C Explanation of Benefits (EOB) – The final rule deletes a requirement for the provision of customized enrollee utilization data and indicates they may require a Part C EOB.

Translated Marketing Materials – The final rule requires plan sponsors to translate marketing materials into any non-English language that is the primary language of at least five percent of the population in the Plan Benefit Package (PBP) service area.

Tiered Cost Sharing in Medicare Advantage Plans – The final rule defers a proposed policy to prohibit tiered cost sharing in Medicare Advantage (MA) plans.

Multi-Ingredient Drug Compounds – The final rule prohibits balance billing for non-Part D Ingredients.

SUMMARY OF PROVISIONS IN THE FINAL RULE

Cost Sharing Limited to FFS – Medicare Advantage and 1876 cost plans may not charge more than FFS for chemotherapy administration, renal dialysis and skilled nursing facility (SNF) services. However plans may charge minimal cost sharing during the first 20 days of SNF while there is no cost sharing in Fee-for-Service (FFS). In the final rule, CMS clarifies that these limits apply to in-network services.

The final rule deletes the requirement in the proposed regulation that would require MA plans to impose no cost sharing on home health services consistent with FFS rules. CMS will perform additional analyses of utilization of home health services in MA and determine whether Congress will enact the MedPAC recommendation that FFS should be amended to include a per episode copayment for home health services.

AFFORDABLE CARE ACT (ACA) PROVISIONS

Annual Coordinated Election Period – The AEP will be October 15-December 7 beginning in 2011 for elections effective January 1, 2012.

45-day MA Disenrollment Period (MADP) – From January 1-February 14, MA enrollees can switch to FFS and a PDP beginning in 2011. The preamble clarifies that the MADP does not give the beneficiary guaranteed issue rights under federal law to prevent underwriting of the Medigap premium.

Fully Integrated DE SNP – The regulation defines a fully integrated Dual-Eligible Special Needs Plan (DE SNP) as a plan that has a capitated contract with the state, coordinates Medicare and Medicaid services (including LTC) through aligned networks, and integrates member materials, communication, grievances and appeals and quality improvement. The final rule clarifies some of the wording of the proposed rule definition.

Extension of SNPs – SNPs can continue to limit enrollment to special needs individuals through the 2013 contract year (except for DE SNPs that do not have a state contract which will continue through December 31, 2012).

NCQA Approval of SNPs – Effective January 1, 2012 all SNPs must be approved by NCQA. NCQA will approve the Model of Care elements. The final rule deleted the provision in the proposed rule that NCQA approve the Quality Improvement (QI) program plan. Based on comments, in the preamble to the final rule CMS stated its intention to implement a multi-year approval process that will allow plans that receive a higher score on NCQA's evaluation of their MOC to be granted a longer approval period. Separate guidance will be issued on this multi-year process. CMS also plans to issue additional guidance on MOC requirements based on the results of their 2011 audits of a sample of SNP MOCs.

Cost Contracts – Competition (non-renewal in areas with two or more coordinated care plans) is delayed until 2013. The rule clarifies that CMS will send out non-renewals to affected cost plans in 2013 that will be effective for contract year 2014.

Senior Housing Facility – Demonstration plans are made permanent. The rule adds these as a new type of coordinated care plan. The preamble clarifies that if a beneficiary moves

out of the senior housing facility, he or she may use the existing Special Election Period (SEP) for change in residence to enroll in another MA or Part D plan or Original Medicare.

Authority to Deny Bids – The rule codifies the Secretary’s authority to deny an MA or Part D bid if it proposes significant increases in cost sharing or decreases benefits. The preamble refers to the Call Letter for criteria that will guide bid review.

LIS Benchmarks - Under the rule, CMS will calculate the LIS benchmark using the basic Part D premium before the application of Part C rebates and the application of quality bonuses.

De Minimis – The final rule has been modified to state that only PDPs (and not MA-PDs) that voluntarily waive a de minimis beneficiary premium for LIS enrollees may receive auto-enrollees and reassigned beneficiaries. While the regulation will include this authority, CMS does not intend to exercise this authority except in limited circumstances, e.g. to allow beneficiaries to remain with the same parent organization or to ensure that beneficiaries in all regions have access to a \$0 plan.

Income Adjusted Premiums – Beginning in 2011, beneficiaries whose income exceeds threshold amounts must pay an income related monthly adjustment amount in addition to the Part D premium. CMS will annually provide information to the Social Security Administration (SSA) for the withholding and collection of these premiums. Beneficiaries who do not pay this amount will be terminated from the Part D plan following a three-month grace period. The income adjusted premium thresholds are frozen at 2010 levels through 2019.

Home and Community-Based Services – Effective January 1, 2012, full benefit Dual-Eligibles (DEs) who are receiving home and community based services will not pay Part D cost sharing. The preamble clarifies that individuals residing in assisted living facilities will qualify only if they otherwise meet other eligibility requirements, e.g. full benefit duals included under a waiver or Medicaid managed care contract. Additional guidance will be issued on Best Available Evidence (BAE) and other operational issues.

Dispensing of Drugs in LTC Facilities – Under the final rule, pharmacies shall dispense brand name drugs in 14-day-or-less increments at a time (rather than the no greater than seven-day increments included in the proposed rule). CMS made this change based on comments questioning potential savings. In the preamble, CMS notes that Part D sponsors can choose seven-day increments. CMS also predicts that the cost of dispensing fees will double but that these costs could be offset, e.g., if plan sponsors provide incentives for adoption of more efficient dispensing techniques or extend the policy to generic drugs or assisted living facilities.

The final rule also modifies the provision in the proposed rule to exclude drugs that are difficult to dispense in the shorter time frame. Instead the final rule requires the 14-day-or-less requirement to apply to solid oral doses of brand name drugs and excludes antibiotics and drugs that are customarily dispensed in their original packaging to assist patients with compliance (e.g. oral contraceptives).

The final rule delays the dispensing and reporting requirements until January 1, 2013. The final rule also provides waivers for I/T/U pharmacies.

Part D plans' pharmacy contracts must include terms and conditions on returns of unused drugs to the pharmacy, including reuse and credit consistent with federal and state laws. The final rule eliminates the requirement that unused drugs be transferred to the pharmacy. For pharmacies that adopt a seven-day-or-less dispensing for all solid oral doses for both brand name and generic drugs, CMS will waive the requirement that Part D sponsor report on the unused drugs as of January 1, 2013 as required for all other sponsors.

The LTC facility will determine the dispensing techniques and copayment methodology. The final rule adds a requirement that the total cost sharing for a Part D drug under the 14-day-or-less standard shall be no greater than without this new standard. Part D sponsors must report to CMS the dispensing methodology used for each dispensing event.

CMS is modifying the definition of dispensing fees to include reasonable pharmacy costs. The rule proposes to waive the requirements for intermediate care facilities for the mentally retarded and developmentally disabled.

MA and PDP Complaint System – The final rule includes a new requirement that plan sponsors respond to complaints received by CMS and report on the resolution to CMS through a drop down checklist or a text box. Plans will be required to link to the CMS-developed model electronic complaint form on the Medicare.gov website.

Uniform Exceptions and Appeals Process – Each PDP must use a single uniform exceptions and appeals process that includes procedures for oral and written requests for coverage determinations and redeterminations by January 1, 2012. Sponsors must use a uniform model form that will be a revision of the current model coverage determination (instead of a new standard form referenced in the proposed rule) and a new separate form for redeterminations (rather than the combined form included in the proposed rule).

Sponsors must provide instant access to enrollees to the coverage determination and appeals process. Based on concerns about the cost of developing an interactive web-based system by 2012, the final rule modifies the requirement into proposed rule to allow plans to use a variety of means. At minimum, the means include secure e-mail to an address that is prominently displayed on the plan's website, as well as immediate access through toll-free customer call centers.

In addition, plans must modify their electronic response transactions to pharmacies instructing pharmacies to provide a plan-specific point-of-sale written notice to enrollees when a prescription cannot be filled that advises them of the right to contact the plan to request a coverage determination. CMS will develop a model point-of-sale notice.

AIDS and IHS Costs - Copayments for supplemental drug coverage provided by the Indian Health Service I/T/U pharmacy and AIDS Drug Assistance Program will count as incurred costs toward TrOOP effective January 2011. The final rule includes technical amendments to the language included in the proposed rule.

Cost Sharing for Prevention Services – The final rule provides that MA organizations provide in-network Medicare-covered preventive benefits at zero cost sharing including the annual wellness visits, the initial preventive physical exam and other preventive services covered by Original Medicare.

Elimination of the Stabilization Fund – The regulation eliminates the MA regional plan stabilization fund.

Medication Therapy Management Program — The regulation includes ACA improvements including a quarterly assessment of all “at risk” individuals not enrolled in MTM programs, opt-out enrollment and quarterly medication review for MTM participants, minimum services including an annual comprehensive medication review using telehealth, and a written report and action plan in a standardized format. Under the final rule, CMS is dropping a proposed requirement that Part D plans must coordinate their MTM programs with the drug regimen reviews performed by LTC consultant pharmacists and will work with stakeholders to develop a policy to coordinate MTM with LTC pharmacist monitoring.

Part D Coverage Gap – The regulation codifies the discount program for brand name drugs in the coverage gap. The regulation includes new definitions for applicable drug, applicable beneficiary and coverage gap. The final rule clarifies the definition that drugs provided through an exception or appeal are “applicable drugs” only for that particular beneficiary and clarifies the definition of coverage gap to reference-enhanced alternative benefit designs. The final rule also excludes vaccine administration fees from the cost sharing reductions.

The regulation codifies the phased down reduction in the rate of growth of the annual out-of-pocket threshold between 2014 and 2019. For 2014-15, the amount will be the amount for the previous year increased by the “annual percentage increase” in the average expenditures for Part D drugs per eligible beneficiary minus 0.25 percent.

The amount for 2016-19 is increased by the lower of the “annual percentage increase” in the CPI plus two percent or the annual percentage increase rounded to the nearest \$50. The amount of the annual out-of-pocket threshold for 2020 and later is calculated as if no change had been made for 2014-2019.

The regulation also codifies the requirement that qualified retiree prescription drug plans not take into account the value of any discount or coverage in the gap when attesting to actuarial equivalence of the plan’s prescription drug coverage to defined standard coverage.

MA Payments – The payment changes in the ACA are self-implementing and are announced in the Annual Announcement of MA Capitation Rates.

Frailty Adjustment for SNPs – Under the regulation, beginning in 2011 payment to fully integrated Dual-Eligible SNPs will include the PACE frailty adjustment if they are a “frailty-qualifying” SNP with “similar” frailty scores to the PACE program. The 2012 Call Letter requires that the level is the minimum PACE frailty level. The frailty qualifying SNPs must fund surveys to support the calculation of the frailty scores at the plan benefit package level.

Coding Adjustment – The regulation codifies the ACA requirement that extends the coding adjustment for differences between MA and FFS indefinitely. It also phases in the provision that increases the coding adjustment to not less than 5.7 percent by 2019. The adjustment applies to risk scores until the Secretary implements risk adjustment using MA diagnostic, cost and use data.

Risk Adjustment for New MA Enrollees in Chronic Care SNPs – Beginning in 2011, the Secretary will use a new risk adjustment method to reflect the underlying chronic health status of new special needs individuals who enroll in a specialized MA plan for special

needs individuals. This adjustment will account for the higher medical and care coordination costs associated with frailty, individuals with co-morbid chronic conditions, individuals with a diagnosis of mental illness, and to account for costs associated with a higher concentration of individuals with these conditions.

MA Payment and Quality Terminology – The regulation adds the term “new MA plan” which for quality rating purposes is a plan that has not had a contract in the preceding three-year period. It also adds the term “low enrollment plan” which is a plan that has insufficient members to undertake HEDIS or HOS data collection. The regulation also modifies the definition of unadjusted MA area-specific non-drug monthly benchmark.

Benchmarks – The regulation includes provisions to implement the new blended benchmarks as the MA county rate and establishes quality based increases in the blended benchmark. The regulation includes the 2-year, 4-year and 6-year phase in periods consistent with the quartile rankings specified in the ACA so that the blended benchmark will be eventually based on 100% of the specified amount. The regulation also includes a provision to average counties that change quartile rankings from year to year.

Quality Bonus Payments (QBP) - The regulation includes provisions to implement the ACA bonuses on a permanent basis, however, the preamble notes that these provisions will be waived for 2012-2014 to allow implementation of a national quality bonus payment demonstration project.

Under the regulation implementing the ACA (but not the quality demonstration), the quality bonus for organizations at the 4- or 5-star level would be phased-in and would be reflected at the organization or contract level, as determined in a Memorandum to Medicare Compliance Officers of MA organizations each calendar year.

The bonus will increase the specified component of the blended benchmark amount 1.5 percentage points in 2012, 3.0 percentage points in 2013 and 5.0 percentage points in 2014 and thereafter. A qualifying organization in a qualifying county would receive a double bonus (i.e. a county that has a 2004 MA urban floor capitation rate for a MSA with more than 250,000 with 25% MA eligibles enrolled in MA plans as of December 2009 and per capita FFS spending lower than the national monthly per capita expenditures under FFS). New MA plans would receive an increase of 1.5% in 2012, 2.5% in 2013, and 3.5% in 2014 and thereafter.

The 5-Star Rating systems is the system currently in place and the regulation clarifies that this system is consistent with the system in place in November 2003. The combined Part C and D summary rating will be used to determine the quality bonus payments. MA contracts that open in a given year but have had other contracts offered by the parent organization offering the new plan in the prior three years would be assigned a star rating based on the average enrollment-weighted performance of the other contracts offered by the parent organization.

The preamble notes that the rating system will be transformed in future years to achieve more comprehensive quality improvement objectives including demonstrable improvements in beneficiary access, health status and outcomes, satisfaction and engagement, prevention and management of chronic conditions and coordination across the continuum of care. The goal is for MA plans to lead the healthcare industry in providing cutting edge, integrated and coordinated care using evidence based and demonstrable metrics.

The MA Quality Strategic Plan will follow the six aims in the “Crossing the Quality Chasm” IOM report (safe, effective, patient centered, timely, efficient and equitable).

Beneficiary Rebates – The regulation implements the ACA provision that changes the share of MA rebates that MA plans provide to enrollees based on the plan’s star rating. These rebates are phased in between 2012-14. The highest possible rebate of 70% of the average per capita savings will be for plans with a 4.5 star or higher rating. The lowest rebate is 50% for plans below 3.5 stars. The rule includes a three-year transition from the old rebate percentage of 75%, e.g. in 2012, two thirds will be based on 75% and one third on the new proportion. The rule also has a transition for low enrollment plans and determining the rebate amount.

Bonus and Rebate Retention Appeals – The regulation includes an administrative review process by a hearing officer of the star rating for quality bonus payment (QBP) determinations and the rebate retention status. The appeals process would be limited to underlying data sets that have not been subject to independent validation. Based on comments, the final rule modifies the appeals process to include a two-step process that includes a request for reconsideration and a request for an informal hearing by a CMS official on the record. The final rule also modifies the timeframes. Medicare Advantage Organizations (MAOs) will have ten business days to request reconsideration and ten days after receiving the determination to request an informal hearing. The regulation would make the appeal process effective after the demonstration program and CMS will issue a separate process to appeal low star ratings during the demonstration project.

PROGRAM PARTICIPATION REQUIREMENTS

Non-contracting Provider Payment Amounts – The rule clarifies that MA plans must pay FFS providers the final amount produced by the pricing software unless the provider specifies in writing that the provider intends to bill less than the amount it would receive under Original Medicare. Regional PPOs must always pay at the full Original payment rate if they are using non-contract providers to meet access requirements.

Pharmacist Definition – The regulation codifies a definition of a pharmacist to have a valid license to practice issued by the appropriate regulatory authority in any of the states, territories or the District of Columbia (DC). This will address audit findings where some plans were using pharmacists not licensed by U.S. authorities to make clinical judgments.

Prohibition on Part C and D Program Participation by Organizations Whose Owners, Directors or Management Employees Served in a Similar Capacity with Another Organization that Terminated its Contract Within the Previous Two Years – The regulation is intended to prevent repackaged versions of the same organizations that dropped out of Part C and D (non-renewed, terminated or mutually terminated). The final rule narrows the definition to focus on individuals with absolute responsibility for control of and ownership stake in the business decision. The final rule clarifies that it applies to persons with more than five percent of stock ownership or five percent of the total property assets.

Timely Transfer of Data and Files when CMS Terminates a Part D Contract – A new regulatory provision is added to require timely transfer of data (e.g. TrOOP balances) and files when CMS terminates a Part D contract.

Medical Review – The final rule clarifies that all MA and Part D organization determinations and redeterminations or reconsiderations involving medical necessity that involve a “denial or partial denial” be reviewed by an appropriate health care professional with sufficient medical and other expertise, appropriate licenses and knowledge of Medicare “coverage”. In addition, MA and Part D organizations will be required to employ a medical director who is responsible for ensuring the clinical accuracy of all medical necessity determinations.

Compliance Officer Training – The proposed rule included a provision that beginning in 2013, MA and Part D plan compliance officers must complete annual MA and Part D compliance training that will include basic working knowledge of the MA and Part D programs and corresponding operational activities in their organization. Based on comments requesting more information on the details of how this would be implemented, the final rule does not include a regulatory provision regarding compliance officer training.

Removing QI Projects and Chronic Care Improvement Programs from MA Deeming - Private accrediting organizations will no longer be deemed to review QIPs and CCIPs. Instead, CMS or a CMS contractor will review these projects and plans. CMS believes this will improve consistency of information used for future plan ratings.

MA Group Health Waiver Plans – CMS is modifying the definition of MA employer group plans to make them consistent with Part D and to preclude offering group and waiver coverage to members of professional associations.

STRENGTHENING BENEFICIARY PROTECTIONS

Agent and Broker Training – To accomplish greater standardization of agent and broker training, CMS is strengthening current requirements for annual training for MA, Cost plans and Part D plans to require that training programs meet minimum CMS standards using a CMS-endorsed or approved training program. The regulation also clarifies that the training requirement applies to all employed as well as all independent agents and brokers.

Call Center and Internet Website Requirements – The regulations codify existing requirements that MA plans must meet the same Call Center and Website requirements that apply to Part D plans. Also regulations codify a current requirement that MA and Part D sponsors must provide interpreters for non-English speaking and limited English proficient callers. The final rule deletes the word “all” and clarifies that MA plans may use on-site interpreters or contract with commercial interpretation providers that support 150 to 180 languages or both. CMS declines to accept a ten percent threshold since plans are not required to ask for language preferences at enrollment.

Unqualified Agents and Brokers – The regulations are adding a provision that when plans terminate an unlicensed agent or broker, they must also notify any beneficiaries who were enrolled by these agents to confirm enrollment or make a change.

Part C Explanation of Benefits (EOB) – In the final rule, CMS has modified its proposal to add a new provision that CMS may require MA and Part D plans to periodically provide each enrollee with “enrollee specific” data to compare utilization and out-of-pocket costs in the current year to projected utilization and out-of-pocket costs for the following year. Rather CMS may require MA plans to provide a written explanation of benefits (EOB) similar to the EOB required under Part D. CMS will run a pilot program in 2012 to test options including an integrated Part C and D EOB.

Mandatory MOOP Requirement – The rule would extend the current MA Mandatory Out-of-Pocket and catastrophic limit that applies to local PPOs to Regional PPOs. Under this modification, CMS rather than the Regional PPO would set the limit on all Part A and B cost sharing.

Prohibition of Tiered Cost Sharing in MA Plans – In the Final Rule, CMS is deferring its proposal to prohibit tiered cost sharing (e.g. that varies cost sharing by provider group). CMS notes that differential cost sharing based on utilization of services is discriminatory and inconsistent with the uniformity requirement.

Delivery of Adverse Coverage Determinations - The rule will modify the Part D requirements to allow an oral notification for the first notice of an adverse standard coverage determination if it is followed up by a written notice within three calendar days. This change should facilitate Part D plans meeting the 72-hour requirement and is consistent with the MA requirement.

Reinstatement of Enrollment for Good Cause – The rule will permit reinstatement of MA or Part D enrollment when a beneficiary was involuntarily disenrolled for failure to pay the plan premium if there is a demonstration of good cause (e.g. unusual or unavoidable circumstances beyond beneficiary control such as an extended hospital stay). Change in the individual's circumstances is not sufficient good cause. The reinstatement must occur within 3 months of disenrollment and the beneficiary must pay all premium delinquencies.

Translated Marketing Materials – Based on comments, CMS will modify the proposed rule and current policy to require MA and Part D plans to translate marketing materials in any language that is spoken by more than 5 (rather than 10) percent of the general population in a plan benefit package service area. Further, CMS will modify the methodology to calculate the threshold by focusing on individuals who primarily speak a non-English language and are not bilingual. Overall, CMS estimates that this new standard will be a net reduction in burden to plan sponsors.

APPROVAL OF STRONGER APPLICANTS AND REMOVAL OF POOR PERFORMERS

Expand Network Adequacy Requirements – The rule would extend the network adequacy requirements to network MSA plans.

Fiscal Soundness – The rule will modify the MA and Part D fiscal soundness regulatory and contract requirements to require that a plan maintains a positive net worth.

Release of Part C and D Payment Data and RDS Data – Under the rule, CMS would release Part C and D aggregate payment data on an annual basis in the year after the year for which payments were made after reconciliation of risk adjustment and payment reconciliation. For Part C, average per member per month (PMPM) payment, rebate and risk score data would be summarized at the plan benefit package (PBP) level for each MA plan. For Part D, average PMPM payments for the direct subsidy, LIS cost sharing subsidy and reinsurance subsidy as well as average risk score would be released at the PBP level. CMS will also disclose payment data related to Part D reconciliation payments and recoveries in the fall of 2011 for 2010.

CMS will also release the following retiree drug subsidy (RDS) data: gross aggregate subsidy amount paid to sponsors and number of unduplicated retirees for each sponsor.

Multi Ingredient Drug Compounds – In conjunction with the use of NCPDP Telecommunications Standard Version D.0 on January 1, 2012, this regulation will codify existing guidance that only compound products that include at least one component that meets the definition of a Part D drug may be covered under Part D and components that do not meet the Part D drug definition are not covered under D. If any component is a Part B drug, then no components may be covered under Part D. The copay must represent the tier for the most expensive Part D ingredient. If a compound is considered on the Part D formulary, then all Part D components are considered on-formulary.

The final rule changes the policy in the proposed rule and prohibits the Part D plan or the pharmacy from balance billing the beneficiary for non-Part D ingredients. The plan's payment to the pharmacy will represent payment in full.

Denial of Applications from Part C and D sponsors with less than 14 Months Experience - Plans must have at least 14 months experience with a Part C or D contract before they can submit a new application or service area expansion. Under this provision, they could not expand until their third year of experience with CMS.

TECHNICAL CHANGES

PSOs – The regulation clarifies that CMS will no longer waive the state license requirement for organizations seeking to offer a Provider Sponsored Organization.

Cost Plan Enrollment – CMS will approve other enrollment mechanisms for cost plans in addition to paper forms, e.g. electronic enrollment. Notice delivery mechanisms other than mailing will also be approved.

Part D Transition - For long term care pharmacies, the final rule would revise the proposed rule and require that the transition fill supply must be at least 91 days and up to 98 days to accommodate multiple fillings of 14 days or less, (unless a lesser amount is prescribed). In addition, one transition notice must be sent to beneficiaries within three business days of adjudication of the first transition fill.

Charges for Emergency Departments – The rule would remove the \$50 cost sharing for CY 2012. Instead, CMS will inform MA plans in annual guidance of the cost sharing amounts.

Clarifications – The proposed rule will clarify confusing language on valid applications and the definition of dispensing fees to include all reasonable costs in all pharmacies including restocking fees in LTC pharmacies.

If you have specific questions regarding the content of this memo, please contact us at ghg@gormanhealthgroup.com.