

# MEMO

**DATE:** August 31, 2011  
**TO:** Clients & Friends  
**FROM:** John Gorman and Jean LeMasurier  
**SUBJECT:** Summary of Final Rule CMS-4131-F and CMS 4130-F

On August 26, 2011, CMS issued two final regulations for Medicare Advantage and Part D provisions enacted in the Medicare Improvement for Patients and Providers Act (MIPPA). These rules address comments from a September 18, 2008 IFC, a November 14, 2008 IFC, and a SNP provision from a January 16, 2009 final rule. Most of the provisions in the interim final rules are adopted in this final rule without changes. Following is a summary of the key changes in the rule.

Access CMS-4131-F and CMS 4138-F at [http://www.ofr.gov/OFRUpload/OFRData/2011-22126\\_PI.pdf](http://www.ofr.gov/OFRUpload/OFRData/2011-22126_PI.pdf).

## D-SNPs

The rule retains the minimum requirements for contracts between D-SNPs and state Medicaid agencies. The preamble notes the establishment of a State Resource Center that can assist plans in contract negotiations with states. The preamble clarifies several of the contract requirements. For example, that D-SNPs must retain responsibility for Medicaid benefits that they provide directly or under contract with another entity; that the contract may be for the entire population of duals or certain categories of duals; that the D-SNP must not impose cost-sharing requirements that exceed the amounts permitted under the State Medicaid plan if the individual were not enrolled in the D-SNP.

The preamble also explains that according to Congressional intent, these state contract requirements only apply to D-SNPs, and not C-SNPs or I-SNPs that serve dual populations.

## SNPs AND QUALITY IMPROVEMENT PROGRAMS

The final rule retains the three-tier system of performance improvement. The preamble notes that CMS will expand its review of the SNP Model of Care (MOC) and in 2012 CMS will assess a sample of SNPs that attained a three-year approval as a result of the NCQA SNP approval process mandated by the ACA.

The preamble discusses the potential for Medicare and Medicaid quality requirements to conflict and that the new Federal Coordinated Health Care Office is considering this issue as part of the Alignment Initiative.

The preamble notes that CMS is streamlining quality reporting for 2012 and that CMS has a contract to develop outcome measures for Medicare Advantage Organizations as well as for SNPs. They will look at specific SNP issues such as low enrollment. The work will be completed in late 2014.

## SNP EXTRA SERVICES AND BENEFITS

The preamble clarifies that SNPs offer some or all of the following benefits that exceed Medicare A and B benefits: (1) no or lower beneficiary cost-sharing; (2) longer benefit coverage periods for inpatient services; (3) longer benefit coverage periods for specialty medical services; (4) parity (equity) between medical and mental health benefits and services; (5) additional preventive health benefits, for example, dental screening, vision screening, health screening, age-appropriate cancer screening, and risk-based cardiac screening; (6) social services, e.g. connection to community resources for economic assistance; (7) transportation services, and (8) wellness programs to prevent the progression of chronic conditions.

## SNP USE OF INTEGRATED SYSTEMS OF COMMUNICATION

The preamble clarifies that an integrated system of communication is the system the plan uses to communicate with all of its stakeholders, e.g. a call center.

## PFFS

In the preamble, CMS states that it does not have the authority to limit the definition of a “network area” to an area with at least two network-based plans offered by different organizations.

## PART D PROMPT PAYMENT OF CLAIMS

Payment for a clean claim is considered to have been made on the date payment for an electronic claim is transferred. *Transferred* means when payment has been made to the payee on the date when funds will be posted to the payee’s account. Payment for a clean claim is considered to have been made on a non-electronic claim when it is submitted to the USPS or common carrier.

*Submitted* is when the payment is postmarked by USPS or recorded as received by the carrier. The Part D plan is fully liable for any interest payments for late claims payment and these costs are not included in administrative costs nor treated as allowable risk corridor costs. The regulatory language is revised to limit CMS authority when determining exigent circumstances under which plans will not be charged interest.

## UPDATE OF PRESCRIPTION DRUG PRICING STANDARD

The final rule clarifies that prescription drug pricing standards apply to “reimbursement” by Part D sponsors.

## MARKETING

The final rule changes the requirement for a 48-hour waiting period if the beneficiary requests information regarding other products to add “when practicable”. The final rule changes the regulatory language to state that the compensation rules apply to payments made by plan sponsors to Field Marketing Organizations (FMOs) as well as the FMOs’ agents.

The final rule clarifies regulatory language that has already been clarified in sub-regulatory guidance, e.g. year means “plan year”; compensation for activities other than selling Medicare products must be at “fair market value”; and that agents do not receive compensation in the case of a rapid disenrollment except in certain circumstances, e.g. when a beneficiary moves out of the area.

The preamble clarifies that the regulation limiting gifts to “potential enrollees” at an event means anyone in attendance at the event. The plan sponsor cannot require an address or phone number in order to receive the gift. CMS states that they do not require plans to create their own scope of appointment forms, but to the extent that they do, CMS requires the plan name and logo. A scope of appointment is required if an agent holds a small group event with individuals who were invited.

## SECTION 1876 COST PLANS

The final rule clarifies the definition of minimum enrollment.

## INFORMATION COLLECTION AND REGULATORY IMPACT

The final rule updates the estimates based on more recent data.

Should you have specific questions regarding the information presented here, please contact Gorman Health Group at 202.364.8283 or at [ghg@gormanhealthgroup.com](mailto:ghg@gormanhealthgroup.com).