



**DEPARTMENT OF HEALTH & HUMAN SERVICES**

Centers for Medicare & Medicaid Services  
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Office of Media Affairs

**Office of Media Affairs**

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## **FACT SHEET**

**FOR IMMEDIATE RELEASE**

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**CMS issues final 2012 policies for Medicare drug and health plans**

*Most policy and technical changes effective in 60 days*

### **Background**

This final rule implements provisions of the Affordable Care Act that are related to the Medicare Advantage (MA, or Part C) and Prescription Drug Benefit (Part D) Programs. This final rule also sets forth programmatic and operational changes to the Medicare Advantage and Prescription Drug Benefit programs for contract year 2012 based on our continued experience with the administration of the Parts C and D programs. The Centers for Medicare & Medicaid Services (CMS) released this final rule on April 4, 2011, in time for plans to prepare their bids for the 2012 contract year. Most provisions will be in effect 60 days after the release of the final rule (see Tables 1 and 2 in the final rule for provisions with different effective dates).

### **FINAL RULE**

The final rule addresses the following:

- Implementing provisions of the Affordable Care Act;
- Clarifying various program participation requirements;
- Strengthening beneficiary protections;
- Strengthening Medicare's ability to identify strong applicants for Medicare Parts C and D program participation and to remove consistently poor performers; and
- Implementing other clarifications and technical changes.

### **Implementing the Provisions of the Affordable Care Act**

Key Affordable Care Act provisions addressed in this final rule include:

- Limiting cost-sharing under Medicare Advantage and section 1876 cost plans for specified services (administration of chemotherapy services, renal dialysis services, and skilled nursing care) to Original Medicare levels.

- Prohibiting Medicare Advantage and section 1876 cost plans from charging cost-sharing for in-network preventive services for which there is no cost sharing under Original Medicare.
- Clarifying that the Secretary is not required to accept all Part C and D bids and clarifying the Secretary's authority to deny bids that propose significant increases in cost-sharing or decreases in benefits.
- Codifying the new beneficiary election periods, including the new annual election period that begins on October 15, 2011.
- Codifying the voluntary de minimis policy for subsidy-eligible individuals enrolled in MA-PD Plans and standalone prescription drug plans.
- Codifying the new requirement that higher income Part D beneficiaries pay an Income Related Monthly Adjustment Amount (Part D-IRMAA).
- Eliminating Part D cost-sharing for Medicare beneficiaries who are eligible for full Medicaid benefits and who are receiving home- and community-based waiver services instead of being institutionalized.
- Codifying statutory changes to close the Part D coverage gap.
- Codifying changes to the Medicare Advantage benchmark calculation and rebate amounts.
- Describing the methodology for using quality ratings to determine Medicare Advantage bonus payments provided for in section 1102 of the Reconciliation Act.
- Reducing waste of Part D drugs in long-term care facilities by requiring dispensing of brand-name prescription drugs in increments of 14 days or less, effective January 1, 2013.
- Establishing policies to implement the ACA's requirement for a more uniform Part D exceptions and appeals process.

### **Clarifying program participation requirements**

These clarifications include:

- Prohibiting Part C and D program participation by Medicare Advantage organizations and Part D sponsors whose owners or directors served in a similar capacity with another organization that terminated its Medicare contract within the previous 2 years.
- Requiring that Part C and Part D organizations (1) use physicians or other appropriate health care professionals with sufficient medical and other expertise, including knowledge of the Medicare program, to review organization determinations involving medical necessity, and (2) employ a Medical Director who is responsible for ensuring the clinical accuracy of all organization determinations and appeals involving medical necessity.

### **Strengthening beneficiary protections**

These provisions include:

- Requiring that Medicare Advantage organizations and Part D sponsors provide interpreters in their customer call centers for all non-English speaking and limited English proficient callers.
- Requiring that Medicare Advantage organizations and Part D sponsors translate key plan marketing materials into any primary language spoken by at least five (5) percent of the population in a given service area.
- Establishing new authority for CMS to require Medicare Advantage plans to periodically mail enrollees an explanation of benefits for their medical benefits. This will help ensure that beneficiaries receive regular updates on their health care usage and out-of-pocket costs so that they can effectively evaluate their options for health care coverage. We will implement a pilot program in 2012 to test a model Part C explanation of benefits document for broader implementation in future years.
- Extending the mandatory maximum out-of-pocket amount requirements to regional preferred provider organizations (RPPOs).
- Requiring pharmacies to provide a printed notice at the point of sale to beneficiaries explaining how to contact their plan to request a coverage determination.
- Requiring Medicare Advantage organizations' and Part D sponsors' agents and brokers to receive training and testing via a CMS-endorsed or approved training program.

**Strengthening CMS' ability to distinguish for approval stronger applicants for Parts C and D program participation and to remove consistently poor performers**

These provisions include:

- Setting requirements for fiscal solvency of plans participating in Part C or D.
- In the absence of 14 months performance history, denying a new application or service area expansion request based on a lack of information available to determine an applicant's capacity to comply with the requirements of the Part C or Part D program.

Cost and savings analysis

- Taking into account both costs and savings estimated as a result of implementation of all 50 proposals in this final rule, CMS estimates a net savings to the Medicare program of about \$76 billion as a result of the provisions in this proposed rule for fiscal years (FYs) 2011 through 2016. Most of these savings are due to the ACA's reforms to Medicare Advantage payments.

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