



CMS 2010 MEDICARE ADVANTAGE & PRESCRIPTION DRUG PLAN SPRING CONFERENCE

Sheraton Baltimore City Hotel, April 20-21, 2010

Verbatim Transcript

CMS rule 4085-F: Policy & Technical Changes to the Medicare Advantage and Medicare Prescription Drug Benefit Programs

Part 1

I'M CHRISTINE HINES.

I WILL BE GOING OVER THE NEWEST
CMS REGULATION, 4085--

POLICY AND TECHNICAL CHANGES
TO THE MEDICARE ADVANTAGE

AND THE MEDICARE PRESCRIPTION
DRUG BENEFIT PROGRAMS.

IT'S GOING TO BE
A BROAD OVERVIEW.

HOPEFULLY, ANY QUESTIONS
THAT YOU HAVE,

YOU CAN SAVE UNTIL SOME
OF THE BREAKOUT SESSIONS,

WHERE YOU WILL HAVE A LITTLE BIT
BETTER RESPONSE

WITH OUR SUBJECT MATTER EXPERTS.

TOWARDS THE END
OF THE FOURTH YEAR

OF THE MEDICARE ADVANTAGE AND THE
PRESCRIPTION DRUG PROGRAM,

CMS REALIZED THAT A NUMBER
OF CHANGES NEEDED TO BE MADE

TO THE PART C AND D
REGULATIONS,

SO THE CHANGES CONTAINED
IN THIS REGULATION

WERE EITHER A REFLECTION

OF THE AGENCY'S KNOWLEDGE

AND EXPERIENCE GAINED
FROM IMPLEMENTING

AND ADMINISTERING
THE PART C AND D PROGRAM,

OR THE CHANGES WERE MADE
TO SPECIFICALLY ADDRESS

THE STATED GOALS TO IMPROVE
UPON THESE PROGRAMS.

IT WAS ISSUED ON APRIL 6,
AND IT APPEARED

IN THE FEDERAL REGISTER
ON APRIL 15, 2010.

THE CHANGES ARE EFFECTIVE
JUNE 7, 2010,

BUT THERE IS A NOTE.

CHANGES ARE APPLICABLE
FOR PLAN YEAR,

OR CONTRACT YEAR, 2011.

WHEN YOU LOOK AT THE REGULATION,

THE PREAMBLE OF THE REGULATION

IS BROKEN DOWN INTO 8 BROAD,

GOAL-FOCUSED CATEGORIES.

SOME ARE STATED GOALS, AND OTHER

ARE MORE GENERIC REVISIONS

TO THE REGULATION OR NEW POLICY,

AND I WILL BE REVIEWING

GENERALLY EACH BROAD CATEGORY

AND SOME OF THE SPECIFIC

REQUIREMENTS AND

REGULATION CHANGES THAT FELL

UNDER EACH CATEGORY.

THE FIRST CATEGORY IS STRENGTHEN
SPONSOR ENTRANCE AND EXIT RULES.

CMS' GOAL IS TO STRENGTHEN
OUR ABILITY TO CONTRACT

WITH STRONG SPONSORING
ORGANIZATIONS

AND TO REMOVE POOR PERFORMERS
FROM THE PART C AND D PROGRAM

BY REVISING APPLICATION
AND COMPLIANCE REQUIREMENTS.

THE FIRST ONE REQUIRES
PART C AND D APPLICANTS

TO SUBMIT NOTICE
OF INTENT TO APPLY,

REVISES THE REGULATION TO REQUIRE
THAT INITIAL APPLICANTS

AND EXISTING CONTRACTORS SEEKING
TO EXPAND SERVICE AREA

OR PRODUCTS COMPLETE
A NONBINDING NOTICE

OF INTENT TO APPLY.

THIS ACTION WILL ENSURE
A MORE EFFICIENT AND EFFECTIVE

APPLICATION PROCESS
WILL TAKE PLACE.

WE ALSO CLARIFY THAT APPLICANTS

MUST MEET ALL
APPLICATION REQUIREMENTS

BY REMOVING SUBSTANTIALLY
ALL LANGUAGE

IN THE REGULATION THAT HAS
CAUSED SOME CONFUSION,

AND WE CLARIFIED
IN THE REGULATION THAT CMS

HAS THE AUTHORITY TO DECLINE
CONSIDERATION

OF APPLICATION MATERIALS
SUBMITTED

AFTER THE EXPIRATION
OF THE 10-DAY PERIOD

FOLLOWING ISSUANCE OF A NOTICE OF
INTENT TO DENY A CONTRACT,

OTHERWISE KNOWN AS
THE 10-DAY "CURE" PERIOD.

THE NEXT SLIDE REPRESENTS
SOME OF THE CHANGES

TO COMPLIANCE ACTIVITIES
TO STRENGTHEN

OUR SPONSOR ENTRANCE
AND EXIT RULES.

FOR COMPLIANCE ACTIVITIES
THAT WOULD STRENGTHEN

OUR ENTRANCE AND EXIT RULES,
WE REPLACED

THE CURRENT CORRECTIVE
ACTION PLAN, OR C.A.P. PROCESS,

WHICH WAS NOT GEARED TOWARDS
A TIMELY ASSESSMENT FOR PLANS

WITH AN OUTCOME-ORIENTED
APPROACH,

ALLOWING A REASONABLE PERIOD OF
TIME TO CORRECT DEFICIENCIES.

CMS WILL PROVIDE ORGANIZATIONS
WITH NOTICE

OF ITS DEFICIENCIES
AND A REASONABLE OPPORTUNITY

OF AT LEAST 30 CALENDAR DAYS

TO DEVELOP AND IMPLEMENT
A C.A.P.

I BELIEVE PRIOR TO THIS,

IT TOOK UP TO 75 DAYS.

WE ALSO CLARIFY THAT
AN OUTLIER ANALYSIS

MAY BE USED
WHEN EVALUATING PERFORMANCE

AND SINCE THERE WAS SOME AMBIGUITY
IN THE REGULATION

WITH RESPECT TO MEASURING
COMPLIANCE

WITH PART D REQUIREMENTS.

WE WILL REQUIRE THAT SPONSORS HIRE
AN INDEPENDENT AUDITOR

TO VERIFY THAT PLAN DEFICIENCIES
HAVE BEEN CORRECTED

AND WILL LIKELY NOT RECUR.

WE CLARIFY THAT CMS MAY
TEMPORARILY IMPOSE

A TEST PERIOD FOR ENROLLMENT
AND MARKETING ACTIVITIES

FOR CERTAIN SANCTIONED
ORGANIZATIONS

TO ENSURE THAT SANCTIONED ACTIVITY
WILL NOT OCCUR AGAIN.

I ACTUALLY THINK WE HAVE

A LITTLE TYPO ON THIS SLIDE.

IT SHOULD NOT SAY "INDIVIDUALS."

IT SHOULD SAY

"ORGANIZATIONS," I BELIEVE,

AND ELIZABETH TOUCHED

UPON SOME OF

THE COMPLIANCE ACTIVITIES

IN THE PRIOR PRESENTATION.

SO THE REGULATIONS
HAD PROVIDED AN OVERLY BROAD
DESCRIPTION OF DEEMABLE
ELEMENTS FOR ACCREDITED
M.A. ORGANIZATIONS
WITH PART D PROGRAMS.
IN THIS PART OF THE REGULATION,
WE REVISED THE DEEMABLE
REQUIREMENTS TO EXCLUDE
THE REQUIREMENT ASSOCIATED
WITH THE AREAS OF FRAUD,
WASTE, AND ABUSE
AND THEN MODIFIED THE REGULATION
THAT SPONSORING ORGANIZATIONS
MUST IMPLEMENT EFFECTIVE
COMPLIANCE PROGRAMS AND PROVIDE
ADDITIONAL CORE REQUIREMENTS
CONCERNING EACH OF THE ELEMENTS
OF SUCH PROGRAMS.
THE NEXT BROAD CATEGORY
IS CHANGES
TO STRENGTHEN
BENEFICIARY PROTECTIONS.
THIS SECTION INCLUDES PROVISIONS
AIMED AT STRENGTHENING
BENEFICIARY PROTECTIONS UNDER BOTH
THE PROGRAMS, C AND D.
THIS FIRST SLIDE UNDER
BENEFICIARY PROTECTIONS
DISCUSSES MARKETING CHANGES.

WE WILL REQUIRE PLANS TO USE
STANDARDIZED MARKETING MATERIALS

WHEN REQUIRED BY CMS.

THIS WILL PROMOTE COMPATIBILITY
OF THE MARKETING MATERIALS,

AND IT WILL, HOPEFULLY, ENSURE THE
MATERIALS THAT PLANS USE

TO COMMUNICATE THE COMPLEX
ASPECTS OF THE C AND D PROGRAMS

ARE UNDERSTANDABLE
TO BENEFICIARIES,

AND THESE CHANGES WILL,
HOPEFULLY, MINIMIZE

BENEFICIARY CONFUSION.

CMS EXTENDED THE MINIMUM
GRACE PERIOD

FOR ENROLLEES
WHO DO NOT PAY PREMIUMS

FROM ONE MONTH TO TWO MONTHS.

INVOLUNTARY DISENROLLMENT
CANNOT OCCUR

BEFORE THE TWO-MONTH
GRACE PERIOD HAS ENDED.

WE ESTABLISH AN OUT-OF-POCKET
MAXIMUM THAT WOULD APPLY

TO LOCAL M.A. PLANS THAT WILL BE
UPDATED ANNUALLY,

ESTABLISHED A CATASTROPHIC CAP

APPLICABLE TO OUT-OF-NETWORK COST
SHARING FOR LOCAL PPOs.

WE ALSO AMENDED
THE PART C REGULATIONS

TO SPECIFY THAT COST SHARING
FOR MEDICARE A AND B SERVICES

MAY NOT EXCEED LEVELS
ANNUALLY DETERMINED BY CMS

TO BE DISCRIMINATORY.

ADDITIONALLY, WE REVISED
THE PART D REGULATION

BY SPECIFYING THAT
TIERED COST SHARING

FOR A NONDEFINED STANDARD
BENEFIT DESIGN

MAY NOT EXCEED LEVELS
ANNUALLY DETERMINED BY CMS

TO BE DISCRIMINATORY.

WE WILL ALLOW
OUT-OF-SERVICE-AREA MEMBERS

OF A PART D PLAN TO CONTINUE
TO BE ENROLLED

FOR UP TO 12 MONTHS
SINCE PDPs GENERALLY HAVE

BROAD NETWORKS
AND MAIL ORDER OPTIONS

THAT WOULD ALLOW THE MEMBER TO
ACCESS BROAD NETWORK SERVICES.

PRIOR TO THIS CHANGE,
WE REQUIRED THE PART D PLAN

TO DISENROLL INDIVIDUALS
WHO WERE ABSENT

FROM THE PDP SERVICE AREA FOR MORE
THAN 6 CONSECUTIVE MONTHS.

THIS ENSURES CONTINUITY
OF BENEFITS

TO THE BENEFICIARY.

WE CODIFIED
THE TRANSITION PROCESS

WE HAVE COMMUNICATED TO PLANS
VIA HPMS MEMORANDA

AND MANUAL INSTRUCTIONS.

GENERALLY, THE TRANSITION
PROCESS IS A PROCESS

ADOPTED BY PLANS TO ALLOW
A BENEFICIARY

TO TRANSITION FROM A DRUG
THAT IS NO LONGER

ON A PLAN'S FORMULARY
TO A DRUG

THAT WILL BE COVERED
ON THE PLAN,

OR IT ALLOWS TIME
FOR THE BENEFICIARY

TO REQUEST AN EXCEPTION
FOR COVERAGE

OF THE DRUG HE OR SHE
IS CURRENTLY TAKING.

WE NOW REQUIRE IN REGULATION
THAT PART D SPONSORS

MUST MAKE REASONABLE EFFORTS
TO NOTIFY PRESCRIBERS

THAT THE ENROLLEE'S PRESCRIPTION
CANNOT BE REFILLED,

EITHER BECAUSE
OF UTILIZATION MANAGEMENT

OR BECAUSE THE MEDICATION
IS NOT LONGER AVAILABLE

ON THE PLAN'S FORMULARY.

Part 2

THIS SLIDE DISCUSSES CHANGES

TO COORDINATION
OF BENEFITS REQUIREMENTS.

WE WILL ESTABLISH TIME LIMITS
ON C.O.V. CLAIMS.

SPECIFICALLY, WE WILL ESTABLISH
A 3-YEAR FILING LIMIT

FOR THESE CLAIMS.

WE WILL REQUIRE THAT SPONSORS
ACCOUNT FOR OTHER PAYERS

WHEN RECONCILING THEIR CLAIMS--

LIKE, SAY PHARMACEUTICAL
ASSISTANCE PROGRAMS

OR LONG-TERM CARE PHARMACIES THAT
MAY HOLD RECEIVABLES--

AND THIS IS IN LIEU OF THE PLAN
SIMPLY ISSUING A CHECK

TO THE BENEFICIARY OR COLLECTING
DIRECTLY FROM THE BENEFICIARY

WHEN RETROACTIVE ADJUSTMENTS
TO CLAIMS RESULT

IN A COST SHARING OVERPAYMENT
OR UNDERPAYMENT.

THERE ARE A NUMBER
OF APPEALS POLICY CHANGES

THAT I WILL NOT GO
INTO DETAIL HERE.

I BELIEVE THERE IS
A BREAKOUT TODAY

AT 3:10 TO DISCUSS THESE
IN MORE DETAIL.

WE ALSO STRENGTHENED MEDICARE
SECONDARY PAYER REQUIREMENTS

BY REQUIRING MEDICARE ADVANTAGE

ORGANIZATIONS

TO REPORT PRIMARY PAYER
INFORMATION

IN ACCORDANCE WITH CMS
INSTRUCTIONS.

THE NEXT BROAD CATEGORY
IS PROVIDE PLAN OFFERINGS

WITH SUFFICIENT ENROLLMENT
AND MEANINGFUL DIFFERENCES.

THE GOAL HERE IS TO ENCOURAGE
ROBUST COMPETITION

WITHIN THE PART C AND D MARKET
WHILE PROVIDING CHOICES

TO OUR BENEFICIARIES
WITH LITTLE CONFUSION.

CMS HAS ESTABLISHED
IN REGULATION

THAT PART C AND D ORGANIZATIONS
FOR A SERVICE AREA

MUST DEMONSTRATE
MEANINGFUL DIFFERENCES

AMONGST PLANS OFFERED.

TO DO THIS, CMS ESTABLISHED
LOW ENROLLMENT REQUIREMENT

AT THE PLAN LEVEL
AND REQUIRES PLANS TO MEET

A MINIMUM ENROLLMENT REQUIREMENT
OR FACE TERMINATION OF THE PLAN.

CMS ALSO HAS THE AUTHORITY
TO REJECT PLAN BENEFIT PACKAGES

WE JUDGE NOT IN THE BEST INTEREST OF
THE BENEFICIARIES

OR FOR REASONS OF DISCRIMINATORY
COST SHARING,

CONFUSING BENEFIT DESIGN,
OR OTHER REASONS

AS DETERMINED BY CMS.

OPERATIONAL ASPECTS OF THE
MEANINGFUL DIFFERENCES POLICY

IS FURTHER DISCUSSED
IN OUR MOST RECENT BENEFITS MEMO

THAT WAS RELEASED ON APRIL 16.

THIS NEXT SECTION IS TITLED

"IMPROVE PAYMENT RULES
AND PROCESSES."

IT CLARIFIED THAT ACTUARIES
WHO VIOLATE STANDARDS

OR DEMONSTRATE LACK
OF PROFESSIONALISM

ARE SUSPENDED OR PROHIBITED
FROM CERTIFYING PLAN BITS.

WE ALSO CLARIFIED IN REGULATION

WHAT ACCEPTABLE
ADMINISTRATION COSTS ARE

FOR 1833 HEALTH CARE
PREPAYMENT PLANS

AND 1876 COST PLANS.

WE FURTHER ELIMINATED
THE 2% MINIMUM UPDATE

AS PART OF THE MINIMUM
PERCENTAGE INCREASE.

THIS SECTION ALSO ESTABLISHED
A TWO-PRONG APPEAL PROCESS

FOR THE RISK ADJUSTMENT DATA
VALIDATION, OR RADV, PROCESS.

M.A. ORGANIZATIONS WILL BE
PERMITTED TO APPEAL

MEDICAL RECORD REVIEW
DETERMINATIONS

AND RADV ERROR CALCULATIONS.

THE NEXT BROAD CATEGORY
IS IMPROVE DATA COLLECTION

FOR OVERSIGHT
AND QUALITY ASSESSMENT,

AND THIS SECTION ADDRESSES
BOTH PART C AND D PROVISIONS

IN ORDER TO IMPROVE PART C AND D
DATA COLLECTION AND USE

FOR OVERSIGHT
AND QUALITY ASSESSMENT.

UNDER THE PRIOR REGULATION,
MEDICARE ADVANTAGE ORGANIZATIONS

HAVE THE FLEXIBILITY
TO DEVELOP THE CRITERIA

FOR CHRONIC CARE
IMPROVEMENT PROGRAMS

AND QUALITY IMPROVEMENT
PROGRAMS.

WE WERE CONCERNED
THAT M.A. ORGANIZATIONS

ESTABLISHING THEIR OWN CHRONIC
CARE IMPROVEMENT PROGRAMS

AND QUALITY IMPROVEMENT
PROJECTS

MAY NOT ADEQUATELY ADDRESS
QUALITY IMPROVEMENT

THAT'S IMPORTANT TO SERVING
OUR BENEFICIARIES.

THEREFORE, WE NOW REQUIRE
M.A. ORGANIZATIONS

TO MEET CMS CRITERIA
FOR SUCH PROGRAMS.

WE ALSO CLARIFIED THAT CMS
HAS THE AUTHORITY

TO COLLECT DATA ON ADDITIONAL
QUALITY AND OUTCOMES MEASURES

AND USE THESE DATA AS PART
OF ITS RATINGS OF PLANS

IN OUR COMPLIANCE ACTIONS.

WE WILL ALSO REQUIRE THAT PLANS
VALIDATE OR AUDIT

THE REPORTED DATA TO ENSURE
DATA SUBMISSIONS ARE COMPLETE

AND CONSISTENT FOR MONITORING AND
ANALYTICAL PURPOSES.

WE WILL REQUIRE
THAT ORGANIZATIONS PAY

FOR CONSUMER ASSESSMENT
OF HEALTH CARE PROVIDERS

AND SYSTEMS, AND THIS
WAS PREVIOUSLY MENTIONED

IN THE 2010 CALL LETTER,
I BELIEVE.

WE REVISED THE LIMITATIONS
ON WHAT CMS CAN ACCESS

FROM PRESCRIPTION DRUG EVENT
DATA RECORDS,

OR PDE RECORDS,
FOR NON-PAYMENT PURPOSES.

WE SPECIFICALLY CLARIFIED
IN THE REGULATION

THAT CMS MAY COLLECT UNDER
CONTRACT WITH PART D SPONSORS

AND RELEASE AT OUR DISCRETION
ADDITIONAL PDE ELEMENTS

THAT HAVE BEEN ADDED
TO THE RECORD SINCE 2006

FOR LEGITIMATE RESEARCH
AND OPERATIONAL PURPOSES.

IT ALSO PERMITS RELEASE
OF PLAN IDENTIFYING INFORMATION

TO HHS GRANTEEES.

THE NEXT CATEGORY IS
TO IMPLEMENT NEW POLICY.

THE DRUG CLASSES
OF CLINICAL CONCERN POLICIES

UNDER MIPPA,
OR THE MEDICARE IMPROVEMENTS

FOR PATIENTS AND PROVIDERS ACT, CMS
WAS REQUIRED TO ESTABLISH

PROTECTED CLASSES
OR CATEGORIES OF DRUGS,

TAKING INTO ACCOUNT RESTRICTED
ACCESS TO THE DRUGS

WOULD HAVE MAJOR
OR LIFE-THREATENING

CLINICAL CONSEQUENCES
FOR INDIVIDUALS

WHO HAVE A DISEASE OR DISORDER
TREATED BY DRUGS

IN SUCH A CLASS OR CATEGORY.

UNDER THE PROPOSED RULE OF 4085,

WE SOLICITED COMMENTS
ON TWO APPROACHES

REGARDING THE PROTECTED CLASSES.

HOWEVER, WITH THE PASSAGE
OF THE PATIENT PROTECTION

AND AFFORDABLE CARE ACT, WHICH
REPLACES MIPPA SECTION 176,

THE LAW NOW REQUIRES
PART D SPONSORS TO INCLUDE

ALL COVERED PART D DRUGS
IN THE CATEGORIES

AND CLASSES OF CLINICAL CONCERN AS
ESTABLISHED BY THE SECRETARY.

UNTIL SUCH TIME AS SECRETARY

CAN ESTABLISH

THESE CLASSES OF DRUGS,
PLANS MUST INCLUDE

ALL COVERED PART D DRUGS
IN THE FOLLOWING CLASSES--

ANTICONVULSANTS,
ANTIDEPRESSANTS,

ANTINEOPLASTICS, ANTIPSYCHOTICS,
AND ANTIRETROVIRALS

AND IMMUNOSUPPRESSANTS

FOR THE TREATMENT
OF TRANSPLANT REJECTION.

WE ALSO ESTABLISHED
THAT BENEFICIARIES WHO ELECT

A MEDICARE MEDICAL
SAVINGS ACCOUNT WILL PAY

ONLY A PRO-RATED DEDUCTIBLE

IF THEIR MSA DEPOSIT
IS PRO-RATED

BECAUSE THEY ENROLL
AFTER JANUARY 1.

WE KIND OF HAD A CATCH-ALL
CATEGORY AT THE VERY END

WHERE WE CLARIFIED VARIOUS
SPONSOR PROGRAM REQUIREMENTS.

IT CLARIFIES IN REGULATION
THAT PART D SPONSORS

MUST, IN LINE WITH PART C RULES,
APPLY UNIFORM PREMIUM BENEFITS

AND LEVEL OF COST SHARING

THROUGHOUT THE PLAN'S
SERVICE AREA

OR BE FOUND IN VIOLATION OF
THE UNIFORM BENEFIT PROVISIONS

OF THIS SECTION

OF THE REGULATION.

THIS IS THE NO WAIVING RULE

WE HAD PROBABLY PUT FORTH
IN INSTRUCTIONS.

THIS JUST FURTHER CLARIFIES
THE UNIFORM BENEFIT RULE

IN REGULATION.

WE PROVIDE FOR A NEW
14 CALENDAR DAY LIMIT

TO DETERMINE OR RESPOND
TO A REIMBURSEMENT REQUEST

UNDER PART D.

PART D SPONSORS ARE REQUIRED
TO NOTIFY AN ENROLLEE

OF PAYMENT DECISIONS
AND MAKE PAYMENT

NO LATER THAN 14 CALENDAR DAYS

AFTER RECEIVING
A REIMBURSEMENT REQUEST.

PRIOR TO THIS CHANGE,
PLANS WERE REQUIRED

TO MAKE A DETERMINATION
WITHIN 72 HOURS,

WHICH WAS A REAL CHALLENGE.

WE CLARIFIED MEDICATION THERAPY
MANAGEMENT PROGRAM REQUIREMENTS

THAT WE HAD PREVIOUSLY ISSUED
IN OUR 2010 CALL LETTER.

IT SPECIFICALLY DEFINES
A TARGETED BENEFICIARY

AND REQUIRES PLANS
TO ENROLL BENEFICIARIES

TARGETED FOR MEDICATION
THERAPY MANAGEMENT

USING AN OPT-OUT METHOD

WHICH IS CONSISTENT
WITH INDUSTRY STANDARD.

TARGET BENEFICIARIES
FOR MTM ENROLLMENT

AT LEAST QUARTERLY
AND OFFER MINIMUM LEVEL

OF MEDICATION THERAPY SERVICES FOR
EACH BENEFICIARY ENROLLED.

ALSO, WE CLARIFIED M.A.
ORGANIZATIONS' OBLIGATION

TO COVER SERVICES OUTSIDE
OF THE SERVICE AREA.

WE WILL REQUIRE IN REGULATION
THAT PLANS THAT INTEND

TO RETAIN ENROLLEES WHEN
OUT OF THEIR SERVICE AREA

FROM 6 TO 12 MONTHS
MUST FURNISH

THE COMPLETE PLAN
BENEFIT PACKAGE

FOR THOSE ENROLLEES,

AND THAT WOULD INCLUDE
PARTS A, PART B,

AND SUPPLEMENTAL BENEFITS

PROVIDED WITHIN
THE SERVICE AREA.

AND FINALLY,
WE HAD ANOTHER SECTION,

MORE TECHNICAL CHANGES
TO THE REGULATION.

FOR EXAMPLE, WE DID CLARIFY
THE DEFINITION

OF GROSS COVERED
PRESCRIPTION DRUG COST

TO ACCOUNT FOR USUAL
AND CUSTOMARY CHARGES

AT NON-NETWORK PHARMACIES.

IN TOTAL--I DIDN'T COVER
ALL OF THEM--

76 PROVISIONS WERE CONTAINED
WITHIN THE RULE,

AND THE REGULATION MAY BE VIEWED
AT THE WEB SITE ON THE SLIDE,

AND THAT IS ALL.

THANK YOU VERY MUCH.

[APPLAUSE]