DEPARTMENT OF HEALTH & HUMAN SERVICES
Centers for Medicare & Medicaid Services
Center for Medicare
7500 Security Boulevard
Baltimore, Maryland 21244-1850

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TO: All Medicare Advantage Organizations, Prescription Drug Plans, Employer/Union-Only Group Waiver Plans and Section 1876 Cost-Based Plans that have a non-renewing contract effective January 1, 2015

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RE: Close-Out Letter for Organizations and Sponsors that are Non-renewing a Contract Effective January 1, 2015

The purpose of this memorandum is to provide post-contract non-renewal requirements for all organizations and sponsors with Medicare Advantage (MA), Medicare Advantage Prescription Drug (MA-PD), Prescription Drug Plan (PDP), Employer/Union-Only Group Waiver Plans and Section 1876 and 1833 Cost-Based Plan contracts that are non-renewing effective January 1, 2015. The close-out letter that follows is divided into two subject areas: (1) "Payment" and (2) "Additional Part C and Part D Requirements." Please follow the applicable instructions for your organization type.

If you have any questions, please contact the specialist listed for that subject area. Please note these instructions are only applicable for contracts that non-renew prior to January 1, 2015.

Close-Out Letter

The following are post-contract non-renewal requirements that all organizations that have a contract that ends December 31, 2014, are responsible for fulfilling beyond December 31, 2014.

Payment

(1) Risk Adjustment Data: All Medicare Advantage (MA), Cost Plans and certain demonstrations with non-renewing contracts are required to submit risk adjustment data and attestations to CMS for the non-renewing contracts. Risk adjustment data includes both Risk Adjustment Processing System (RAPS) data and Encounter Data. The due dates are as follows:

a. January 2013 through December 2013 dates of service must be submitted by January 31, 2015; and
b. January 2014 through December 2014 dates of service must be submitted by March 6, 2015.
c. Any data corrections being submitted to correct an overpayment must be submitted to CMS by March 6, 2015.

For any questions related to Risk Adjustment submissions, please email: riskadjustment@cms.hhs.gov.

(2) Prescription Drug Data: MA-PD and PDP organizations/sponsors are currently required to submit prescription drug event (PDE) data and direct and indirect remuneration (DIR) data to CMS. This requirement also pertains to non-renewing contracts that are part of these organizations/sponsors. In accordance with section 1.4.1 of the Instructions-Requirements for Submitting Prescription Drug Event Data, organizations/sponsors must submit PDE records "to CMS electronically at least once a month." In accordance with the May 16, 2011 HPMS memorandum titled, "The timely submission of PDE records and the resolution of rejected PDEs," and the subsequent HPMS memorandum titled, "Revisions to the original PDE submission timeframes," organizations/sponsors must submit original PDE records to CMS within thirty days following Date Claim Received or Date of Service (whichever is greater), organizations/sponsors must resolve rejected records and re-submit the PDEs within 90 days following receipt of the rejected record status from CMS, PDE adjustments must be submitted within 90 days of discovery, and adjustments and deletions must be submitted within 90 days following discovery of the issue requiring change. Organizations/sponsors with non-renewing contracts must submit all 2014 PDE data pertaining to these contracts to CMS by the final submission deadline, which is 11:59 PM Eastern Time (ET), on the federal business day immediately before June 30. For benefit year 2014 PDEs, this deadline will be 11:59 PM ET on June 29, 2015. PDEs submitted after this deadline will not be considered in the 2014 Part D payment reconciliation.

In accordance with 42 CFR § 423.336(c)(1), organizations/sponsors with non-renewing contracts are required to submit the 2014 DIR Report for Payment Reconciliation corresponding to these contracts by June 30, 2015. Non-renewing contracts should reference the Final Medicare Part D DIR Reporting Requirements for 2014, which CMS will release in the spring of 2015. Please note that the data submission deadlines for both PDE data and DIR data apply to all plans, not

just non-renewing plans. CMS reserves the right to adjust these deadlines based on operational considerations. In accordance with 42 CFR § 423.505(k)(5), organizations/sponsors with non-renewing contracts are also required to submit "the Attestation of Data Relating to CMS Payment to a Medicare Part D Sponsor," "the Attestation of Plan-to-Plan (P2P) Reconciliation Payment Data," and "the Attestation of Data Relating to Detailed DIR Report" prior to the 2014 Part D Payment Reconciliation. Non-renewing organizations/sponsors should reference 2014 guidance regarding the submission of this attestation, which CMS will release via HPMS in the summer of 2015.

(3) Access to CMS Reports: CMS stops sending plan payment reports to Plans for non-renewed contracts 61 days after termination. When CMS conducts the final settlement for a non-renewed contract (see "Final Reconciliation" below), it will send the Plan all of the Monthly Membership Reports (MMRs) for that contract that were created between the date of non-renewal and final settlement. The MMRs will detail all of the retroactive adjustments that accumulated in the system for the non-renewing contract after termination.

(4) Access to CMS Systems: In order to comply with Federal privacy and security laws and guidance, CMS must terminate system access for all users of a non-renewed contract. System access for non-renewing contracts will end 60 days after a contract non-renews. Please note that a Plan will retain access to HPMS in order to perform certain functions for a non-renewing contract, such as reporting direct and indirect remuneration to CMS.

(5) Retroactive Payment Adjustments: Plans that need to submit payment adjustments after non-renewal should do so by submitting corrected information to the Retroactive Processing Contractor, currently Reed & Associates, within 45 days from the date of its last monthly payment report. The requested corrections will be verified and, if verified, applied to the Plan's member records. These corrections will be included in the Plan's final payment reconciliation.

(6) Final Reconciliation: CMS will complete the final reconciliation for contracts that non-renew in 2014 after the final risk adjustment, Part D, and Coverage Gap Discount Program annual reconciliations for 2014 have been performed. CMS expects to complete the final reconciliation and settlement of 2014 non-renewed plans in mid to late 2016. However, it is important to note that completion of final reconciliation may be delayed if a Plan fails to comply with its remaining data submission requirements.

(7) Disenrollment Transaction Processing: Non-renewing contracts are required to submit disenrollment transactions for members who request to disenroll prior to the non-renewal date, (i.e. effective December 1, 2014), according to the usual disenrollment request processing requirements as provided in CMS Enrollment and Disenrollment Guidance. This must be accomplished while your contract still has access to CMS systems. Transactions for disenrollments that occur because of the non-renewal should not be submitted.

(8) Claims: Organizations and sponsors are required by regulation (42 CFR §422.101(a), §422.505(b), and 42 CFR §423.104(a),§423.506(b)) to provide their enrollees with benefits for the full 12-month term (January 1 through December 31) of their contract with CMS. Consequently, organizations (including those with non-renewing contracts) must fully honor claims related to covered services provided to their members during the 12-month term but received by the organization or sponsor after the close of the contract year, in accordance with the applicable contract terms.

(9) TrOOP Balance Transfer: Part D sponsors are required by regulation (42 CFR §423.464 (f)(viii)) to comply with all administrative processes and requirements established by CMS to ensure effective exchange of information and coordination between entities that provide other prescription drug coverage, including other Part D plans. We consider compliance with our true out-of-pocket (TrOOP) balance process and timelines to be a part of these requirements. Sponsors are required to track beneficiary TrOOP costs and correctly apply these costs to the annual out-of-pocket threshold to provide catastrophic coverage at the appropriate time. For beneficiaries who changed Part D sponsors during the coverage year, CMS' automated TrOOP balance transfer guidance in Chapter 14 of the Medicare Prescription Drug Benefit Manual requires that all Part D sponsors must correctly calculate the TrOOP amount in order to properly adjudicate beneficiary claims, as well as to communicate this information to plan members.

Automated TrOOP balance transfer transactions continue until March of the following year to permit the transfer of updated accumulator data, claims adjustment to be made based on the updated information and the reporting of new/revised PDE records. Since CMS continues to receive PDEs for a contract year until June of the year following, a non-renewing contract must continue to process the prior year's claims/adjustments and TrOOP balance transfer transactions and submit PDE records until June (see No. 3 above).

(10) 1876 and 1833 Cost-Based Plans Cost Reports: CMS requires that all Section 1833 and 1876 Cost-Based Plans that are non-renewed at the close of 2014 to submit final cost reports by April 30, 2015 and June 30, 2015, respectively. All non-renewing cost plans are subject to audit and should keep all records and documentation necessary to support costs reported on their final and open year cost reports.

Additional Part C and Part D Requirements

(1) Corrective Action Plans: Organizations currently operating under a corrective action plan (CAP) must continue to fulfill the requirements of the CAP through December 31, 2014, unless CMS informs otherwise.

(2) HEDIS/CAHPS/Health Outcome Survey: Organizations with non-renewing contracts will not be required to submit HEDIS 2015 data for those contracts (i.e., HEDlS results from the 2014 measurement year) nor to participate in the Health Outcome Survey (HOS) baseline and follow-up surveys administered in 2015. Further, organizations and sponsors will not have to participate in the CAHPS survey administered in 2015. ***(HEDIS and HOS do not apply to stand-alone PDPs.)***

(3) Quality Improvement Projects (QIPs) and Chronic Care Improvement Program (CCIPs): Organizations are required by regulation and contract to implement QIPs and CCIPs. Both require periodic reporting at the request of CMS. CMS will not require organizations with non-renewing contracts to report this information for those contracts. ***(This does not apply to stand-alone PDPs.)***

(4) Maintenance of Records: In accordance with 42 CFR § 422.504 (d) and (e) and §423.505 (d) and (e), organizations/sponsors are required to maintain and provide CMS access to its records. Specifically, organizations/sponsors must maintain books, records, documents and other evidence of accounting procedures and practices for 10 years. These regulations also detail the requirements for government access to organizations'/sponsors' facilities and records for audits that can extend through 10 years from the end of the final contract period or completion of an audit, whichever is later. That time period can be extended in certain circumstances, as detailed in this regulation. For service area reductions, the dates for the records pertaining to the area that was reduced run from the time the particular county or counties were removed from the service area. For cost plans records maintenance requirements please see 42 CFR § 417.126.

(5) Continuation of Care: If a Medicare beneficiary is hospitalized in a prospective payment system (PPS) hospital, the organization with the non-renewing contract is responsible for all Part A inpatient hospital services until the beneficiary is discharged, as stated in 42 CFR § 422.318. Original Medicare or the beneficiary's new organization will assume payment responsibility for all other covered services on the effective date of contact non-renewal. If a Medicare beneficiary is in a non-PPS hospital, the organization with the non-renewing contract is responsible for the covered charges through the last day of the contract or, for contracts reducing their service area, the last day that the beneficiary was enrolled in the MA plan.

With respect to enrollees receiving care in a skilled nursing facility (SNF), organizations with non-renewing contracts are financially liable for care through the end of the contract year. After that date, Medicare beneficiaries continuing in a SNF may receive coverage through either Original Medicare or another MA plan. If the SNF stay is Medicare covered, the number of days of the beneficiary's SNF stay while enrolled in a MA plan will be counted toward the 100-day limit. ***(This requirement does not apply to Part D Sponsors.)***

(6) Pending Appeals: Part C and Part D appeals decided in favor of the appealing party after the date that the organization's/sponsor's contract non-renews must be effectuated by the (former) organization/sponsor in accordance with the regulations. The regulations at 42 CFR § 422.504(a)(3) require organizations to provide access to benefits for the duration of its contract. The regulations also require organizations to pay for, authorize, or provide services that an adjudicator determines should have been covered by the organization. Therefore, organizations are obligated to process any appeals, as governed by 42 CFR Part 422, Subpart M, for services that, if originally approved, would have been provided or paid for while Medicare beneficiaries were enrolled in their plan. Additionally, 42 CFR § 422.100 (b)(1)(v) provides that organizations must make timely and reasonable payment to non-contracting providers and suppliers for services which coverage has been denied by the organization and found upon appeal to be services the enrollee was entitled to have furnished or paid for, by the organization. Similarly, the regulations at 42 CFR § 423.505(b)(4) require Part D plan sponsors to provide access to benefits for the duration of its contract. Also, the language in 42 CFR §§423.636 and 423.638 requires Part D plan sponsors to authorize, provide, or make payment for a benefit that an adjudicator determines should have been covered by the plan sponsor. Therefore, plan sponsors are obligated to process any appeals, as governed by 42 CFR Part 423, Subparts M and U, for prescription drugs that, if originally approved, would have been authorized, provided or paid for while Medicare beneficiaries were enrolled in their plan.

The rights, procedures, and requirements relating to beneficiary appeals and grievances set forth in 42 CFR Part 422, Subpart M also apply to Medicare contracts with HMOs and Competitive Medical Plans under section 1876 of the Act.

(7) Reporting Requirements: Organizations/sponsors with non-renewing contracts are not required to fulfill the new Part C and Part D reporting requirements. Data that are due after the organization's/sponsor's last contract year are no longer required to be submitted, and, in fact, should not be submitted. Also, those organizations/sponsors are not required to undergo the Part C/D Data Validation.

(8) Overpayments: Organizations/sponsors with non-renewing contracts are required to adhere to 42 CFR 422.326 and 42 CFR 423.360. These regulations require that an organization/sponsor report and return overpayments to CMS in the form and manner set forth in regulation.

(9) Data and Files: Part D Sponsors with non-renewing contracts are required to adhere to 42 CFR § 423.507(a) (4). This regulation requires Part D sponsors with non-renewing contracts to ensure the timely transfer of any data or files.

(10) Customer Service: Following completion of the contract year, all members of a non-renewing plan should be provided continued member access to Plan information for sixty (60) days past the beginning of the next calendar year (January 1 to March 1). Plan websites containing non-renewing plan information and customer service lines should continue to be operational. Toll free call center numbers for non-renewing plans will continue seven days a week from at least 8:00 A.M. to 8:00 P.M., corresponding to the time zones in which they

operate. During this time period, enrollees in the non-renewed plan must be able to speak with a live customer service representative. Please refer to section 80.1, of the *Medicare Marketing Guidelines* for customer service call center requirements.

(11) HPMS Complaint Tracking Module (CTM): Part D sponsors with non-renewing contracts are required to document, resolve, and close out all complaints received via CTM related to events that occurred prior to December 31, 2014 in accordance with CMS guidance and instructions.

(12) Medicare Part D Patient Safety and Opioid Overutilization Monitoring System: Part D sponsors with non-renewing contracts are required to respond to inquiries related to Patient Safety activities and the Overutilization Monitoring System tickets for 18 months following completion of the contract year. This includes responding to inquiries from Part D sponsors that serve beneficiaries who were previously enrolled in the non-renewed contract. To facilitate this, non-renewed contracts will be provided access to the Patient Safety Analysis Website and the Medicare Part D Overutilization Monitoring System for two years following contract close-out.

Please submit any questions related to the Part C or Part D requirements in this section of the letter to the nonrenewal mailbox located at https://dmao.lmi.org.