DEPARTMENT OF HEALTH & HUMAN SERVICES
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MEDICARE-MEDICAID COORDINATION OFFICE

DATE: October 28, 2016

TO: All New York Fully Integrated Duals Advantage (FIDA) organizations with a non-renewing contract effective on or before January 1, 2017

FROM: Lindsay P. Barnette, Director
Models, Demonstrations, and Analysis Group
Medicare-Medicaid Coordination Office

RE: Close-Out Letter for New York FIDA Plans that are Non-Renewing a Contract Effective on or before January 1, 2017

The purpose of this memorandum is to provide post-contract non-renewal requirements for all Fully Integrated Duals Advantage (FIDA) plan contracts that are non-renewing effective on or before January 1, 2017. This memorandum contains your organization's obligations to the Centers for Medicare & Medicaid Services (CMS) and the New York State Department of Health (NYSDOH) moving forward. The close-out letter that follows is divided into two subject areas: (1) "Payment" and (2) "Additional FIDA Plan and Part D Requirements." Please follow the applicable instructions for your organization type.

Please note this memorandum is only applicable for FIDA Plan contracts that non-renewing on or before January 1, 2017.

The following are post-contract non-renewal requirements that all organizations that have a contract that ends December 31, 2016, are responsible for fulfilling beyond their contract termination date. Additionally, your organization must adhere to the following requirements that are applicable to your contract.

Payment

Risk Adjustment Data (including Encounter Data): FIDA Plans with non-renewing contracts are required to submit all risk adjustment data and attestations to CMS and NYSDOH for its non-renewing FIDA Plan. Risk adjustment data includes both Risk Adjustment Processing System (RAPS) data and Encounter Data Processing System (EDPS). The due dates are as follows:

a) January 2015 through December 2015 dates of service must be submitted by January 31, 2017; and
b) January 2016 through December 2016 dates of service must be submitted before the contract loses access to CMS systems (see below).

For any questions related to RAPS submissions, please email: riskadjustment@cms.hhs.gov. For any questions related to EDPS submissions, please email: MMCOcapsmodel@cms.hhs.gov and encounterdata@cms.hhs.gov.

Prescription Drug Data: MA-PD and PDP organizations/sponsors, including FIDA Plans, 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 and sponsors. In accordance with section 1.4.1 of the Instructions-Requirements for Submitting Prescription Drug Event Data, organizations and 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 and sponsors must submit original PDE records to CMS within thirty days following Date Claim Received or Date of Service (whichever is greater), organizations and 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 and sponsors with non-renewing contracts must submit all 2016 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 2016 PDEs, this deadline will be 11:59 PM ET on June 29, 2017. PDEs submitted after this deadline will not be considered in the 2016 Part D payment reconciliation.

In accordance with 42 CFR § 423.336(c)(1), organizations and sponsors with non-renewing contracts are required to submit the 2016 DIR Report for Payment Reconciliation corresponding to these contracts by June 30, 2017. Non-renewing contracts should reference the Final Medicare Part D DIR Reporting Requirements for 2016, which CMS will release in the spring of 2017. Please note that the data submission deadlines for both PDE data and DIR data apply to all organizations and sponsors, not just non-renewing organizations and sponsors. CMS reserves the right to adjust these deadlines based on operational considerations. In accordance with 42 CFR § 423.505(k)(5), organizations and 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 2016 Part D Payment Reconciliation. Non-renewing organizations and sponsors should reference 2016 guidance regarding the submission of this attestation, which CMS will release via HPMS in the summer of 2017.

Medical Loss Ratio (MLR): Organizations and sponsors with non-renewing contracts are required to submit the MLR Report and Attestation to CMS in a manner consistent with 42 CFR § 422.2460 and §423.2460, with the modifications to the MLR requirements as noted in the Three-Way Contract. The MLR Report and Attestation for CY 2015 will be due to CMS in late 2016. CMS will provide further guidance on MLR reporting for MMPs, including modifications to the MLR report. Questions regarding MLR may be emailed to MMCOcapsmodel@cms.hhs.gov.

Overpayments: FIDA Plans are required to adhere to 42 CFR §422.326 and 42 CFR §423.360, and these provisions continue to apply to non-renewing contracts. These regulations require that an organization/sponsor report and return overpayments to CMS.

Risk adjustment data (including encounter data) corrections submitted to correct an overpayment must be submitted to CMS before the contract loses access to CMS systems (see below). Once the contract no longer has access to CMS systems, the organization can no longer submit data to CMS to correct an overpayment. However, if a non-renewed organization/sponsor identifies an overpayment after this point, the organization/sponsor must report and return the overpayment to CMS in a manner consistent with the February 18, 2015, HPMS memorandum, "Guidance for Reporting and Returning Medicare Advantage Organization and/or Sponsor Identified Overpayments to the Centers for Medicare & Medicaid Services (CMS)," for returning overpayments in the "other" category.

PDE or DIR data corrections submitted to correct an overpayment must be submitted to CMS in accordance with 42 CFR §423.360 and applicable guidance. Questions regarding this process may be emailed to pdejan2011@cms.hhs.gov

Access to CMS Reports and Systems: CMS stops sending plan payment reports to organizations for non-renewing contracts 61 days after their non-renewal date. However, organizations will stop receiving the monthly Plan Payment Report (PPR) the month in which the contract is scheduled for termination.

When CMS conducts the final settlement for a non-renewed contract (see "Final Reconciliation/Settlement" below), CMS will send the organization 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 non-renewal.

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 terminates. Please note that an organization will retain access to

HPMS in order to perform certain functions for a non-renewing contract, such as reporting DIR data to CMS.

Retroactive Payment Adjustments: Organizations that need to submit retroactive enrollment transactions, and State and County Code changes that can cause a retroactive payment adjustment 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.

Final Reconciliation/Settlement: CMS's final settlement phase for non-renewing contracts lasts for a minimum of 18 months after the end of the calendar year in which the contract termination date occurs. Organizations and sponsors can expect a final settlement package from CMS for 2016 terminated contracts after July 2018. This final settlement package will include reconciliation of any demonstration-specific payments or recoupments, including those related to quality withhold repayments, and MLR recoupments as applicable, that are outstanding at the time of termination. However, it is important to note that completion of final reconciliation/settlement may be delayed if an organization/sponsor fails to comply with its remaining data submission requirements. Other annual reconciliations must occur prior to a terminating contract's final reconciliation/settlement which includes: 1) 2016 final risk adjustment reconciliation, 2) 2016 Part D annual reconciliation, and 3) 2016 Coverage Gap Discount Program annual reconciliations.

NYSDOH will complete final reconciliation of its accounts with the non-renewing organization approximately nine months after the end date of its FIDA Plan program agreement, which is September 30, 2017. However, it is important to note that completion of final reconciliation may be delayed in the event that the non-renewing FIDA Plan fails to comply with its remaining data submission requirements. For more information on the Medicaid final reconciliation, please contact Jack Pitera at jack.pitera@health.ny.gov

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 24-month term (January 1, 2015 through December 31, 2016) of their contract with CMS. Consequently, organizations (including those with non-renewal contracts) must fully honor claims related to covered services provided to their members during the 24-month term, but received by the organization or sponsor after the close of the contract year, in accordance with the applicable contract terms.

True Out-of-Pocket (TrOOP) Balance Transfer: Part D sponsors are required by regulation (42 CFR §423.464 (a)) 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. CMS considers compliance with its 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 enrollees who changed Part D sponsors during the coverage year, all Part D sponsors are required by regulation (42 CFR 423.464(f)(2)(b)) to report, accept and apply benefit accumulator data in a timeframe and manner determined by CMS. CMS' automated TrOOP balance transfer guidance in Chapter 14 of the Medicare Prescription Drug Benefit Manual states 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.

Beginning in 2017, the time period for the automated transfer of TrOOP accumulator data will be extended to eventually cover the full 36-month coordination of benefits period. Part D sponsors must be able to accept and respond to Financial Information Reporting (FIR) transactions triggered under the enhanced automated TrOOP balance transfer (ATBT) process for years in the extended time period. Therefore, sponsors must ensure that their FIR processors are contracted to handle transactions for the current as well as all prior years covered under the enhanced ATBT process. For some sponsors, this may entail re-contracting with a former processor to process prior year FIR transactions.

Additional FIDA Plan and Part D Requirements

Health Effectiveness Data and Information Set (HEDIS)/Consumer Assessment of Healthcare Providers and Systems (CAHPS)/Health Outcome Survey (HOS): FIDA Plans with non-renewing contracts will be required to submit 2017 HEDIS data for those contracts (i.e., HEDIS results from the 2016 measurement year). FIDA Plans with non-renewing contracts will not be required to participate in 2017 HOS baseline and follow-up (i.e. based on 2016 experience) and will not be required to participate in the 2017 CAHPS Survey.

Quality Improvement Projects (QIPs) and Chronic Care Improvement Program (CCIPs) reports: FIDA Plans will not be required to submit 2016 QIP and CCIP updates to CMS and NYSDOH.

Maintenance of Records: In accordance with 42 CFR §422.504(d) and (e), §423.505 (d) and (e), and Section 5.4 of the three-way contract, FIDA Plans are required to maintain and provide CMS and NYSDOH with access to their records. Specifically, organizations and 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. For service area reductions, the time period for which the records must be maintained begins the day the particular county or counties were removed from the service area.

Continuation of Care: If an enrollee is hospitalized in a prospective payment system (PPS) hospital, FIDA Plans are responsible for all Part A inpatient hospital services until the participant is discharged, as stated in 42 CFR §422.318. Original Medicare or the enrollee's new organization will assume payment for all other services covered under Medicare Part B on the effective date of contract non-renewal. If an enrollee is in a non-PPS hospital, FIDA Plans with

the non-renewing contracts are responsible for the covered charges through the last day of its contract or, for contracts reducing their service area, the last day that the enrollee was enrolled in the plan.

With respect to enrollees receiving care in a skilled nursing facility (SNF), FIDA Plans with non-renewing contracts are financially liable for care through the end of the contract year. After that date, enrollees 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 enrollee's SNF stay while enrolled in a FIDA Plan will be counted toward the 100-day Medicare limit.

An example, if a participant in your plan entered a SNF under a new Medicare benefit period on December 1, 2016 and was disenrolled on December 31, 2016, 30 days of the stay would be covered by your organization, leaving 70 days of Medicare fee-for-service coverage beginning January 1, 2017. Those participants who enroll in another FIDA Plan or Medicare Advantage plan will receive SNF coverage beginning January 1, 2017, according to the CMS-approved benefit package offered by that plan.

Pending Appeals: Both FIDA Plan 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 at 42 CFR §422.504(a)(3) and the three-way contract.

The regulations at 42 CFR §422.504(a)(3) require a FIDA Plan to provide access to benefits for the duration of their 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. Similarly, Section 2.9 of the FIDA Plan three-way Contract requires FIDA Plans to "[e]xcept for services that do not require authorization as outlined in Section 2.9.3, the IDT, FIDA Plan, or specified specialist must authorize, arrange, coordinate and provide to Participants Medically Necessary Covered Items and Services as specified in the IDT Policy and Appendix A." Further, Section 2.13.1.1.2.14 of the three-way contract requires that if the services were not furnished while the appeal was pending and a decision is reversed by an adjudicator, the FIDA Plan "must authorize or provide the disputed services immediately (within no more than one (1) Business Day), and as expeditiously as the Participant's health condition requires." 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 for 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.

In addition, Section 2.13.1.1.2.14 requires FIDA Plans to provide for the "[c]ontinuation of benefits for all prior-approved Medicare and Medicaid benefits that are terminated or modified, pending internal FIDA Plan Appeals, Integrated Administrative Hearings, and Medicare Appeals Council … if the original Appeal is requested to the FIDA Plan within ten (10) calendar days of the notice's postmark date (of the decision that is being appealed) or by the intended effective date of the Action, whichever is later." Section 2.13.1.1.2.14 also requires that the Participant

shall not be liable for the cost of any continued benefits even if the FIDA Plan's action is upheld. Therefore, for all Appeals of prior-approved Medicare and Medicaid benefits requested to the FIDA Plan in accordance with the timeline in Section 2.13.1.1.2.14, even if the appeal is submitted after non-renewal of the contract, FIDA Plans are obligated to provide aid continuing up to the non-renewal date of the contract. For services addressed in the Final Reconciliation/Settlement paragraph above that are continuing pending an appeal pursuant Section 2.13.1.1.2.14 as of December 31, 2016, FIDA Plans must provide for the Continuation of Care pursuant the provisions in the Final Reconciliation/Settlement paragraph.

Similarly, the regulations at 42 CFR §423.505(b)(4) require Part D sponsors, including FIDA Plans, to provide access to benefits for the duration of their contracts. Also, the language in 42 CFR §423.636 and §423.638 requires that a Part D sponsors, including FIDA Plans, authorize, provide, or make payment for benefits that an adjudicator determines should have been covered by the sponsor. Therefore, as with FIDA Plan appeals described above, the 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 enrollees were enrolled in their FIDA 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.

Reporting Requirements: Unless otherwise specified in writing by CMS and NYSDOH in a subsequent letter, FIDA Plans will be required to submit all quality measures required for participation in the FIDA Demonstration. This includes measures outlined in the August 10, 2016 Core Medicare-Medicaid Capitated Financial Alignment Model Reporting Requirements and October 1, 2015 New York-specific Reporting Requirements. FIDA Plans will report all measures covering its performance from January 1, 2015 through December 31, 2016, including measures due after December 31, 2016 for which some or all of the period of performance is prior to December 31, 2016.

Data and Files: Part D Sponsors, including FIDA Plans, with non-renewing contracts are required to adhere to 42 CFR § 423.507(a) (5). This regulation requires Part D sponsors with non-renewing contracts to ensure the timely transfer of any data or files.

NYSDOH Reporting: FIDA Plans will be required to submit to NYSDOH a quarterly financial report on November 15, 2016, for Quarter 3 of the program, and the annual report on April 1, 2017.

Provider Network Data Systems (NYSDOH PNDS) Reporting: The entire FIDA Provider Network must be submitted through the NYSDOH Health Commerce System (HCS) no later than 15 business days after December 31, 2016 (by January 22, 2017).

Customer Service: Following completion of the contract year, organizations and sponsors must provide all enrollees of a non-renewing plan continued enrollee access to plan information for 60 days past the beginning of the next calendar year (January 1 to March 1). Organizations and

sponsors must continue to operate websites containing non-renewing plan information and customer service lines. 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-renewing organizations'/sponsors' 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.

Health Plan Management System (HPMS) Complaint Tracking Module (CTM): FIDA Plans with non-renewing contracts are required to document, resolve, and close out all complaints received via the CTM related to events that occurred prior to December 31, 2016 in accordance with CMS guidance and instructions.

Information Sharing: Pursuant to Section 5.3.8 of the three-way contract, FIDA Plans are required to arrange for the transfer, at no cost to CMS, NYSDOH, or the participant, of medical information regarding such participant to any subsequent provider of medical services as may be requested by the participant, or subsequent provider, or as directed by CMS or NYSDOH. Information from the participant's Medical Record, Comprehensive Assessment, and Person Centered Service Plan must be transferred to NYSDOH sources upon request.

Pursuant to Section 2.3.2.10 of the three-way contract, the FIDA Plan shall transfer the Participant's Comprehensive Health Record information promptly to the new FIDA plan or NYSDOH or its designee as appropriate upon Disenrollment of the Participant from the Demonstration or at the Participant's request to transfer to another FIDA plan in accordance with Section 5.2.4 of the three-way contract; and if the Participant transfers to another FIDA plan, with the Participant's written consent, and in accordance with applicable laws and regulations, transfer current Minimum Data Set-Home Care (MDS-HC) or Minimum Data Set-Nursing Facility (MDS-NF) assessment information to the new FIDA plan. The information shall be provided no later than ten (10) calendar days from the receipt of the notice of Disenrollment to the FIDA plan and no later than the effective date of transfer in the method and format specified by NYSDOH and CMS.

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

Thank you for your attention to these matters. If you have any questions, please contact your Contract Management Team or the Medicare-Medicaid Coordination Office at MMCOcapsmodel@cms.hhs.gov.