DEPARTMENT OF HEALTH & HUMAN SERVICES
Centers for Medicare & Medicaid Services
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CENTER FOR MEDICARE

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TO: All Medicare Advantage Organizations, Prescription Drug Plans, Employer/Union-Only Group Waiver Plans and Section 1876 Cost-Based Plans with Contracts that will Non-Renew in 2011

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Subject: Close-Out Letter for Organizations with a Contract that Ends in 2011

The purpose of this communication is to provide post-contract non-renewal requirements for all Medicare Advantage Organizations, Prescription Drug Plans, Employer/Union-Only Group Waiver Plans and Section 1876 Cost-Based Plans that have a contract that will end at the close of 2011. The close-out letter that follows is divided into two subject areas: Payment and 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. Again, these instructions are only applicable for contracts that non-renew prior to January 1, 2012.

Close-Out Letter

The following are post-contract non-renewal requirements that all organizations that have a contract that ends at the close of 2011 are responsible for fulfilling beyond December 31, 2011.

Payment

(1) Risk Adjustment: MA and MA-PD organizations are currently required to submit hospital inpatient, hospital outpatient, and physician diagnostic data for risk adjustment to CMS. Organizations with non-renewing contracts are also required to submit all risk adjustment data pertaining to these contracts to CMS as follows: 1) January 2010 through December 2010 dates of service must be submitted by January 31, 2012; and 2) January 2011 through December 2011 dates of service must be submitted by March 4, 2012. For organizations with non-renewing contracts, March 4, 2012 will be the final risk adjustment data submission deadline for reporting diagnoses for 2011 dates of service rendered under these contracts. Plan-reported demographic corrections must be received within 45 days from the date of the last CMS report to the Retroactive Adjustment Processing Contractor.

(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. Throughout the coverage year, CMS will monitor PDE data submission levels to detect contracts with submission volumes lower than expected. In accordance with the May 16, 2011 HPMS memorandum referenced above, organizations/sponsors with non-renewing contracts must submit all 2011 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 2011 PDEs, this deadline will be 11:59 PM ET on June 29, 2012. PDEs submitted after this deadline will not be considered in the 2011 Part D payment reconciliation.

In accordance with 42 CFR § 423.336(c)(1), organizations/sponsors with non-renewing contracts are required to submit the 2011 DIR Report for Payment Reconciliation corresponding to these contracts by June 30, 2012. Non-renewing contracts should reference the Final Medicare Part D DIR Reporting Requirements for Payment Reconciliation for 2011, which CMS will release in the spring of 2012. 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" prior to the 2011 Part D Payment Reconciliation. In submitting this attestation, MA-PD and PDP organizations/sponsors certify that the PDE data, DIR data, and any other information provided for the purposes of determining allowable reinsurance and risk corridor costs are accurate, complete, and truthful. Non-renewing organizations/sponsors should reference 2011 guidance regarding the submission of this attestation, which CMS will release via HPMS in the summer of 2012.

(3) Retroactive Adjustments for Payment and Enrollment: In accordance with section 70.2 of Chapter 11 of the Medicare Managed Care Manual, organizations with non-renewing contracts are required to reimburse CMS for any overpayments. Conversely, an organization may seek reimbursement from CMS for any previously identified underpayments. Organizations seeking payment adjustments must submit corrected information within 45 days from the date of receipt of the organization's January payment Monthly reports (scheduled for receipt on December 22, 2011). Organizations must confirm those corrections on the February reports (available on January 25, 2012) and send any additional corrections to the Retroactive Adjustment Processing Contractor, Reed Associates. The reporting of valid corrected information to Reed Associates will trigger the CMS retroactive payment adjustment process. The reported corrections will be verified and applied to the records of the organization's members. These corrections will be included as a part of the organization's final payment reconciliation after the final risk adjustment reconciliation and Part D payment reconciliation are completed for 2011.

CMS will complete final reconciliation of its accounts with organizations approximately nine to twelve months (or, if applicable, after the final risk adjustment reconciliation and Part D payment reconciliation for 2011 are performed), after the end date of the non-renewing contract, December 31, 2011. However, the completion of the final reconciliation may be delayed in the event an organization fails to comply with data submission requirements for risk adjustment or Part D payment reconciliation. For MA and PDP organizations/sponsors that are also reducing service areas for contracts that will continue in 2012, no final reconciliation will be performed. Payment adjustments related to coverage provided in the discontinued portions of the service area will be included as part of the regular payment adjustment process and will appear in the monthly payments during 2012.

Additionally, MARx monthly reports will no longer be available 61 days after a contract non-renews. Copies of Monthly Membership Reports (MMRs) created after that date will accompany the final reconciliation results from CMS after the risk adjustment and Part D reconciliations for 2011 have been completed.

(4) Disenrollment Transaction Processing: For the most part, organizations with non-renewing contracts do not need to submit disenrollment transactions and beneficiaries do not need to request disenrollment, except as described below. 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, 2011), according to the usual disenrollment request processing

requirements as provided in CMS Enrollment guidance. This must be accomplished while your contract still has access to CMS systems.

(5) Access to CMS Systems: All user access to CMS systems (MARx, MBD, and BEQ) related to the contract will end 60 days after the contract is non-renewed. If access to CMS systems is required for your contract after 60 days, please contact Marla Kilbourne at Marla.Kilbourne@cms.hhs.gov or Michelle Page at Michelle.Page@cms.hhs.gov. If inactive contracts need assistance obtaining DDPS or PRS reports, please contact the CSSC Operations at 1-877-534-CSSC or csscoperations@palmettogba.com.

(6) Claims: Organizations are required by regulation (for Part C 42 CFR § 422.101(a) and 42 CFR § 422.505(b), and for Part D 42 CFR § 423.104(a) and 42 CFR § 423.506(b)) to provide their enrollees with benefits for the full 12-month term (January 1, 2011 through December 31, 2011) 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 MA organization or Part D sponsor after the close of the contract year, in accordance with the applicable contract terms.

(7) 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.

(8) 1876 Cost-Based Plans: CMS requires all terminated Section 1876 Cost-Based Plans to submit a final cost report by June 30, 2012. All terminating cost plans will be audited and should keep all records and documentation necessary to support costs reported on their final and open year cost reports.

For any questions related to the Payment section, please contact Natasha Facey at Natasha.Facey@cms.hhs.gov.

Additional Part C *and Part D Requirements*

(1) Corrective Action Plans (CAPs): Organizations currently operating under a corrective action plan must continue to fulfill the requirements of the CAP through December 31, 2011, unless CMS informs otherwise.

(2) HEDIS/CAHPS: MA organizations with non-renewing contracts will not be required to submit HEDIS 2012 data for those contracts (i.e., HEDlS results from the 2011 measurement

year), and MA organizations and Part D sponsors will not have to participate in CAHPS 2012 that is administered starting in February 2012 for non-renewing contracts. ***(HEDIS does not apply to Part D Sponsors.)***

(3) Quality Improvement Projects (QIPs) and Chronic Care Improvement Program (CCIP): MA organizations are required by regulation and contract to perform annual QIPs and to implement a CCIP. 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 Part D Sponsors.)***

(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.

(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 MA organization will assume payment for all services covered. 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 was part of the approved service area in a particular county.

With respect to enrollees receiving care in a skilled nursing facility (SNF), MA organizations with non-renewing contracts are financially liable for care through December 31, 2011. 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 non-renewing organization's 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 MA organizations to provide access to benefits for the duration of its contract. The regulations also require MA organizations to "pay for, authorize, or provide services that an adjudicator determines should have been covered by the organization". Therefore, MA 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 MA organizations "must make timely and reasonable payment to ... non-contracting providers and suppliers ...for services which coverage has been denied by the MA organization and found upon appeal to be services the enrollee was entitled to have furnished or paid for, by the MA 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, both Part C organizations and Part D sponsors are obligated to effectuate appeals decided in favor of the appealing party after the date that the organization's/sponsor's contract terminates.

(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) 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.

(9) Marketing Guidance: Following completion of the contract year, all members of a non-renewing plan are to be provided continued member access to Plan information. Plan websites containing non-renewing plan information and customer service lines are to continue to be operational for sixty (60) days past the beginning of the next calendar year (January 1 to March 1), as outlined in 80.1-Customer Service Call Center Requirements in the *Medicare Marketing Guidelines*. 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 send any questions related to the Part C requirements in this section of the letter to Nonrenewals@cms.hhs.gov. For questions related to Part D requirements, please contact Betty Burrier at Betty.Burrier@cms.hhs.gov.