DEPARTMENT OF HEALTH & HUMAN SERVICES
Centers for Medicare & Medicaid Services
7500 Security Boulevard, Mail Stop C4-21-26
Baltimore, Maryland 21244-1850

CENTER FOR MEDICARE

DATE: November 30, 2015

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, 2016

FROM: Kathryn A. Coleman, Director
Medicare Drug & Health Plan Contract Administration Group

Amy K. Larrick, Acting Director
Medicare Drug Benefit and C & D Data Group

Gerard Mulcahy, Director
Medicare Parts C & D Oversight & Enforcement Group

Cheri Rice, Director
Medicare Plan Payment Group

Arrah Tabe-Bedward, Director
Medicare Enrollment & Appeals Group

RE: Close-Out Letter for Organizations and Sponsors that are Non-Renewing a Contract Effective January 1, 2016

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, 2016. 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.

A separate memorandum will be issued with the close-out instructions for non-renewing Medicare Medicaid Plans.

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, 2016.

Close-Out Letter

The following are post-contract non-renewal requirements that all organizations that have a contract that ends December 31, 2015, are responsible for fulfilling beyond December 31, 2015.

Payment

(1) Risk Adjustment Data (including Encounter Data): All 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 2014 through December 2014 dates of service must be submitted by February 1, 2016; and
b. January 2015 through December 2015 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 Encounter Data submissions, please email: encounterdata@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 2015 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 2015 PDEs, this deadline will be 11:59 PM ET on June 29, 2016. PDEs submitted after this deadline will not be considered in the 2015 Part D payment reconciliation.

In accordance with 42 CFR §423.336(c)(1), organizations/sponsors with non-renewing contracts are required to submit the 2015 DIR Report for Payment Reconciliation corresponding to these contracts by June 30, 2016. Non-renewing contracts should reference the Final Medicare Part D DIR Reporting Requirements for 2015, which CMS will release in the spring of 2016. Please note that the data submission deadlines for both PDE data and DIR data apply to all organizations/sponsors, not just non-renewing organizations/sponsors. 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 2015 Part D Payment Reconciliation. Non-renewing organizations/sponsors should reference 2015 guidance regarding the submission of this attestation, which CMS will release via HPMS in the summer of 2016.

(3) Medical Loss Ratio (MLR): Organizations/sponsors with non-renewing contracts are required to submit the annual MLR Report and Attestation to CMS in a manner consistent with 42 CFR §422.2460 and §423.2460. The MLR Report and Attestation for CY 2015 will be due to CMS in late 2016. Questions regarding MLR may be emailed to MLRreport@cms.hhs.gov.

(4) Overpayments: All organizations/sponsors 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/sponsor can no longer submit data to CMS to correct an overpayment. However, if a terminated 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.

(5) Access to CMS Reports: CMS stops sending plan payment reports to organizations/sponsors 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 organization/sponsor 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.

(6) Access to CMS Systems: In order to comply with Federal privacy and security laws and guidance, CMS must terminate system access for all users associated with a non-renewed contract. Generally, system access for these users will end 60 days after a contract non-renews. However, please note that users will retain access to HPMS in order to perform certain functions that remain for a non-renewing contract, including, but not limited to, reporting direct and indirect remuneration data (DIR) to CMS.

(7) Retroactive Payment Adjustments: Organizations/sponsors 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 organizations/sponsors enrollee records. These corrections will be included in the

organizations/sponsors final payment reconciliation.

(8) Final Reconciliation/Settlement: CMS's final settlement phase for non-renewing contracts lasts for a minimum of eighteen months after the termination date of the contract. Organizations/sponsors can expect a final settlement package from CMS for 2015 terminated contracts after July 2017. 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 non-renewing contract's final reconciliation/settlement which includes: 1) 2015 final risk adjustment reconciliation, 2) 2015 Part D annual reconciliation, and 3) 2015 Coverage Gap Discount Program annual reconciliations.

(9) Disenrollment Transaction Processing: Non-renewing contracts are required to submit disenrollment transactions for enrollees who request to disenroll prior to the non-renewal date, (i.e. effective December 1, 2015), according to the usual disenrollment request processing requirements as provided in CMS Enrollment and Disenrollment Guidance. This must be accomplished while the contract users still have access to CMS systems. Transactions for disenrollments that occur because of the non-renewal should not be submitted.

(10) Claims: Organizations/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 and sponsors (including those with non-renewing contracts) must fully honor claims related to covered services and prescriptions provided to their enrollees 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.

(11) 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 sponsors. 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 enrollee 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 plans 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 enrollee claims, as well as to communicate this information to plan enrollees.

Beginning in 2016, 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.

(12) 1876 and 1833 Cost-Based Plans Cost Reports: CMS requires that all Section 1833 and 1876 Cost-Based Plans that non-renew submit final cost reports by April 30, 2016 and June 30, 2016, 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/sponsors currently operating under a corrective action plan (CAP) must continue to fulfill the requirements of the CAP through December 31, 2015, unless CMS informs otherwise.

(2) HEDIS/CAHPS/Health Outcome Survey: Organizations/sponsors with non-renewing contracts will not be required to submit HEDIS 2016 data for those contracts (i.e., HEDIS results from the 2015 measurement year) nor to participate in the Health Outcome Survey (HOS) baseline and follow-up surveys administered in 2016. Further, organizations/sponsors will not have to participate in the CAHPS survey administered in 2016. ***(HEDIS and HOS do not apply to stand-alone PDPs.)***

(3) Quality Improvement Projects (QIPs) and Chronic Care Improvement Program (CCIPs): Organizations/sponsors are required by regulation and contract to implement QIPs and CCIPs. Both require periodic reporting at the request of CMS. CMS requires organizations/sponsors with non-renewing contracts to provide a final QIP and CCIP Annual Update for those contracts, including any results to date along with lessons learned and best practices. ***(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 section 1876 cost plans records maintenance requirements please see 42 CFR §417.480 and §417.568; for section 1833 cost plans see §417.806.

(5) Continuation of Care: If an enrollee 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 enrollee is discharged, as stated in 42 CFR §422.318. Original Medicare or the enrollee's new organization will assume payment responsibility for all other covered services on the effective date of contact non-renewal. If an enrollee 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 enrollee 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, 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 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 enrollees 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 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 sponsors to authorize, provide, or make payment for a benefit that an adjudicator determines should have been covered by the sponsor. Therefore, 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 plan.

The rights, procedures, and requirements relating to enrollee 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 and 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)(5). This regulation requires Part D sponsors with non-renewing contracts to ensure the timely transfer of any data or files.

(9) Customer Service: Following completion of the contract year, organizations/sponsors must provide all enrollees of a non-renewing plan continued enrollee access to plan information for sixty (60) days past the beginning of the next calendar year (January 1 to March 1). Organizations/sponsors must continue to operate websites containing non-renewing information and customer service lines. Toll free call center numbers for non-renewing organizations/sponsors must

continue to operate 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 organizations'/sponsors' non-renewed organization/sponsor 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.

(10) HPMS Complaint Tracking Module (CTM): Organizations/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, 2015 in accordance with CMS guidance and instructions.

(11) 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 enrollees 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.