DEPARTMENT OF HEALTH & HUMAN SERVICES
Centers for Medicare & Medicaid Services
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MEDICARE-MEDICAID COORDINATION OFFICE

DATE: December 1, 2015

TO: All New York Fully Integrated Duals Advantage (FIDA) organizations with a non-renewing contract effective January 1, 2016

FROM: Sharon Donovan, Director
Program Alignment Group, Medicare-Medicaid Coordination Office

RE: Close-Out Letter for New York FIDA plans 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 Fully Integrated Duals Advantage (FIDA) plan contracts that are non-renewing effective January 1, 2016. This memorandum contains your organization's obligations to 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 effective 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. Additionally, your organization must adhere to the following requirements that are applicable to your contract.

Payment

(1) Risk Adjustment Data (including Encounter Data): FIDA plans will be 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. The due dates are as follows:

a) January 2015 through December 2015 dates of service must be submitted by 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: MMCOcapsmodel@cms.hhs.gov and encounterdata@cms.hhs.gov.

(2) 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/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 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 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 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.

(4) 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 identifies an overpayment, the organization 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 plans for non-renewing contracts 61 days after non-renewal. 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 non-renewal.

(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 of a non-renewal contract. Generally, system access for these users will end 60 days after a contract non-renews. However, please note that a plan will retain access to HPMS in order to perform certain functions for a non-renewing contract, including, but not limited to, reporting direct and indirect remuneration data (DIR) to CMS.

(7) Retroactive Payment Adjustments: Plans 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 participant records. These corrections will be included in the Plan's 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 non-renewal date of the contract. Plans can expect a final settlement package from CMS for 2015 non-renewed contracts after July 2017. However, it is important to note that completion of final reconciliation/settlement may be delayed if a Plan 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.

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, 2016. 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 final reconciliation, please contact Jack Pitera at jack.pitera@health.ny.gov

(9) 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-renewal 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.

(10) 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. 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, 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 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 FIR transactions triggered under the enhanced 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

(11) HEDIS/HOS/CAHPS: FIDA plans will be required to submit 2016 HEDIS data (i.e., HEDIS results from the 2015 measurement year), but will not be required to participate in 2016 CAHPS or HOS (i.e. based on 2015 experience).

(12) Quality Improvement Projects (QIP) and Chronic Care Improvement Program (CCIP) reports: FIDA plans will not be required to submit 2015 QIP and CCIP updates to CMS and NYSDOH.

(13) 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 access to its records. Specifically, FIDA plans 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.

(14) Continuation of Care: If a Medicare beneficiary 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 participant's next Medicare managed care organization will assume payment for all services covered under Medicare Part B. If a Medicare participant is in a non-PPS hospital, FIDA plans are responsible for the covered charges through the last day of its contract.

With respect to participants receiving care in a skilled nursing facility (SNF), FIDA plans are liable for such care through December 31, 2015. After that date, Medicare participants continuing in a SNF stay may receive coverage through either Original Medicare or another MA plan. If the SNF participants' stay is Medicare covered, the number of days of the participant'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, 2015 and was disenrolled on December 31, 2015, 30 days of the stay would be

covered by your organization, leaving 70 days of Medicare fee-for-service coverage beginning January 1, 2016. Those participants who enroll in another FIDA plan or Medicare Advantage plan will receive SNF coverage beginning January 1, 2016, according to the CMS-approved benefit package offered by that plan.

(15) 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 applicable regulations 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 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. 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) provides that FIDA plans must make timely and reasonable payment to non-contracting providers and suppliers for services for which coverage has been denied by the FIDA plan and found upon appeal to be services the enrollee was entitled to have furnished or paid for.

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 Paragraph 8 above that are continuing pending an appeal pursuant Section 2.13.1.1.2.14 as of December 31, 2015, FIDA plans must provide for the Continuation of Care pursuant the provisions in paragraph 8.

Finally, the regulations at 42 CFR §423.505(b)(4) require a Part D plan sponsor, including a FIDA plan, to provide access to benefits for the duration of its contract. Also, the language in 42 CFR §§423.636 and 423.638 requires that a Part D plan sponsor, including a FIDA plan, authorize, provide, or make payment for benefits that an adjudicator determines should have

been covered by the plan sponsor. Therefore, as with FIDA plan appeals described above, the non-renewing plan is 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 the 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.

(16) 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 plan Demonstration. This includes measures outlined in the October 29, 2014 Core Medicare-Medicaid Capitated Financial Alignment Model Reporting Requirements and April 16, 2015 New York-specific Reporting Requirements. FIDA plans will report all measures covering its performance from January 1, 2015 through December 31, 2015, including measures due after December 31, 2015 for which some or all of the period of performance is prior to December 31, 2015.

(17) 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.

(18) NYSDOH Reporting: FIDA plans will be required to submit to NYSDOH a quarterly financial report on November 15, 2015, for Quarter 3 of the program, and the annual report on April 1, 2016.

(19) 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, 2015 (by January 22, 2015).

(20) 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-renewing 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.

(21) HPMS Complaint Tracking Module (CTM): FIDA plans are required to document, resolve, and close out all complaints received via CTM related to events that occurred prior to January 1, 2016 in accordance with CMS guidance and instructions.

(22) 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.

(23) 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-renewing 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.