**[Tab A -- Non-Renewal and Service Area Reduction Guidance****]**

## Notices and Letters

### *Interim Model Beneficiary Letter for Non-Renewing MA, MA-PD and Cost-Based Organizations*

CMS expects MA, MA-PD and Cost-Based plans non-renewing and/or reducing service areas to inform the affected members of the upcoming changes to their benefits, including plan benefit plans, as soon as possible. Issuing an interim letter to inform your beneficiaries of the upcoming changes will avoid confusion and will assist beneficiaries in preparing for selecting another coverage option. CMS anticipates the affected members receiving the interim letter from your organization before issuing the final beneficiary notice. PDP sponsors are not required to issue an interim letter to their beneficiaries.

All beneficiary notification letters, including the Model Interim Beneficiary Letter, must be reviewed and approved by the appropriate CMS Regional Office (RO) prior to release. These notification letters must be entered into HPMS. Plans are encouraged to use the model Interim Beneficiary Letter in order to receive an expedited 10 day review. The Model Interim Non-Renewing Letter is at the end of this guidance.

If you have questions or concerns about accessing the model interim beneficiary letter, please contact the HPMS help desk at 1-800-220-2028 or [HPMS@cms.hhs.gov](mailto:HPMS@cms.hhs.gov). Be sure to include your user ID.

### *Final Notification Letter of Non-Renewal to Beneficiaries*

#### *Delivery Deadline for Final Beneficiary Letter*

Although MA, MA-PD, PDP, EGWP and cost-based plans, technically can mail the final beneficiary letter at any time as long as it is received by the affected beneficiaries no later than November 2, 2009, CMS expects these non-renewing organizations to send out the personalized final beneficiary notification letter in early October. **If your organization is not able to mail the notice prior to October 15, 2009, please inform your CMS account manager of your inability to execute the mailing as requested.** Additionally, CMS recommends that organizations use first class postage for letters mailed close to the required delivery deadline. Regardless of when the letters are mailed, all MA, MA-PD and cost-based plan letters must be dated November 2, 2009 to ensure national consistency in the application of Medigap guaranteed issue rights to all beneficiaries. PDP letters can be dated with the current date that reflects the date that the letter is printed. Note: EGWP sponsors non-renewing a non-calendar year plan with the plan year ending before December 31st, will need to have the final beneficiary notification letter be received by affected beneficiaries 60 days before the plan year end date.

1. *Content and Format for Final Beneficiary Letter*

The Final Beneficiary Notification Letters for all types of organizations are at the end of this guidance. Please choose the letter that applies to your type of organization.

CMS will no longer prepare the “State-Specific” Model Final Notification Letter that MA organizations must use if they serve beneficiaries in one of the 24 states that have certain special Medigap protections beyond Federal law requirements. These states are California, Colorado, Connecticut, Kansas, Louisiana, Maine, Maryland, Massachusetts, Michigan, Minnesota, Mississippi, Missouri, New Hampshire, New Jersey, New York, North Carolina, Oklahoma, Oregon, Pennsylvania, South Dakota, Texas, Vermont, Washington, and Wisconsin. Instead, CMS will advise our SHIP partners so that they can provide the appropriate state specific Medigap information when they are contacted by beneficiaries.

Sections 422.506(a)(2)(ii) and 423.507(a)(2)(ii) of the CFR require non-renewal notices to “***include a written description of alternatives available*** for obtaining Medicare services (or qualified prescription drug coverage) ***within the service area (or PDP region),*** including ***alternative MA plans (and other PDPs)…”***  Your organization is required to include a list of replacement plans in the affected service areas.

MA, MA-PD and cost-based organizations have access to Contracts Reports --“Replacement Organizations – Service Area Losing Organizations for CY 2010” which provides each non-renewing MA Organization a replacement organization list of those Medicare health plan organizations/sponsors, which will be available to affected beneficiaries as alternative choice in 2010. The Medicare Compliance Officers for each non-renewing PDP sponsor will receive a replacement organization list directly from CMS. This list should include the following: Contract Number, Name of Organization, Service Areas, Customer Service Phone Number, TTY Phone Number, and Contract Type.

MA, MA-PD and cost-based organizations that encounter any problems with the HPMS module, please contact the HPMS Help Desk at 1/800-220-2028 or [HPMS@cms.hhs.gov](mailto:HPMS@cms.hhs.gov).

MA, MA-PD, PDP, and cost-based organizations **cannot** include information about their own Medicare supplemental policies in the body of the final notification letter. As this final notification letter is critical to impacted Medicare beneficiaries, CMS strongly recommends highlighting the outside of the envelope with the headings used in the appropriate final notification letter. An example printed on the envelope would be: “**IMPORTANT NOTICE:** Your Medicare Coverage Is Changing”.

Information on Medicare supplemental policies and any other marketing materials must be mailed in a stand-alone mailing following the final notification letter. If the non-renewing organization wishes to provide additional marketing materials on other product options, it may do so separately in a subsequent mailing. All regular marketing review requirements apply.

EGWPs may customize the Model Final Beneficiary Notification Letter to the extent that modifications will more clearly and accurately reflect the benefits available to EGWP enrollees. The final notification letter, for both Part C and Part D should be on 8 ½” x 11” papers and mailed in a similarly sized envelope. The letter must be individualized to enable affected beneficiaries to prove their special rights to Medigap insurers and other Medicare organizations.

Under separate cover, CMS will inform Part C, Part D and cost-based organizations that remain in the Medicare program for 2010 of their responsibilities regarding non-renewal activity in the area and the Special Election Period (SEP).

#### *CMS Regional Office Review*

All final beneficiary notification letters must be reviewed and approved by the appropriate CMS Regional Office (RO) prior to release. Non-renewing plans may not modify the final notification letter. The final notification letter must be entered into HPMS.

*All final notification letters should be submitted in time for the review to be completed no later than October 1, 2009, and organizations are strongly encouraged to submit it early so that the letter can be sent to beneficiaries in early October.* Organizations should consider this review period when they make plans to meet the required deadlines.

CMS has waived the prior review and approval requirements for all EGWPs. Therefore, EGWPs are not required to submit or receive approval of their final beneficiary notification letters from CMS RO staff.

### *Medigap Information*

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*(Guidance below for Cost & MA Organizations)*

Non-renewing MA organizations must inform all of their Medicare beneficiaries, including those who are eligible for Medicare due to a disability and individuals with End Stage Renal Disease (ESRD), about their Medigap rights. Full information on this topic is provided in the enclosed “What You Should Know About Medigap” and the “State Specific" information can be received by contacting your local SHIP office or the State Department of Insurance. This model language will ensure accurate communication of these provisions.

*(Guidance below for MA, MA-PD organizations)*

Special rules apply for affected beneficiaries in a managed care trial period. These individuals must actively and voluntarily disenroll from their non-renewing MA plans in order to choose from a broader range of Medigap policies available on a guaranteed issue basis. MA organizations must provide these beneficiaries with written documentation of their voluntary disenrollment, even if the voluntary request is made for a December 31, 2009, effective date. Beneficiaries may be required to submit this written documentation to a Medigap issuer as proof of their right to purchase certain guaranteed issue Medigap policies. CMS Model Letters for Voluntary Disenrollmentare found in the Medicare Managed Care Manual, Chapter 2, on CMS’ website at

<http://www.cms.hhs.gov/MedicareMangCareEligEnrol/Downloads/MAEnrollmentGuidanceUpdate.pdf>.

*(Guidance below for Cost-Based Organizations)*

Medicare cost-based organizations are required to provide or arrange for supplemental coverage of benefits related to a pre-existing condition with respect to any exclusion period for all Medicare beneficiaries age 65 or older. For beneficiaries under age 65 who are entitled to Medicare due to a disability or ESRD, the cost-based organization must arrange for supplemental coverage if it is available in the marketplace. Please see §1876(c)(3)(F) and under CMS (HCFA) Medicare Cost Plan contract provision, Article IV, General Conditions, item R.

CMS regulations do not require provision of guaranteed issue (i.e., no medical screening, or coverage of pre-existing conditions) Medigap policies, if such a policy is not available for sale in the marketplace. If Medigap issuers in a particular state do not sell Medigap policies to beneficiaries who are eligible for Medicare due to a disability, the Medicare Cost-Based organization must provide supplemental coverage for pre-existing conditions.

The Medicare Managed Care Manual (CHAPTER 17, Sub-Part F, 10.5) states that “the beneficiary must be provided all medically necessary benefits covered in the plan in which they enroll (including supplemental benefits) at the time of their initial enrollment. Waiting periods or exclusions from coverage, due to pre-existing conditions, are not permitted.”

The terms of the Agreement signed by Medicare cost-based organizations also refers to the requirement that, should the cost-based organization non-renew, it must provide or arrange for supplemental coverage for Medicare benefits related to pre-existing conditions with respect to any exclusion period for "the lesser of six months or the duration of such period." See language at Article IV.R.

NAIC and HIPAA define "pre-existing conditions" as those "limited to a physical or mental condition for which medical advice, diagnosis, care or treatment was recommended or received within the 6 month period ending on the enrollment date in a plan or policy."

CMS's interpretation is that coverage for pre-existing conditions for the disabled is a requirement whether a disabled beneficiary: 1) applies for and obtains a Medigap policy with a pre-existing condition exclusion; or 2) applies for and is denied coverage under a Medigap policy. Individuals who are eligible for Medicare due to age have similar protections. The beneficiary will still need to be provided coverage for pre-existing conditions, even if the cost-based organization has to provide such coverage directly. CMS believes that an individual who is eligible for Medicare due to a disability must make an attempt to obtain a Medigap policy before the cost-based organization can be required to provide coverage directly. The Medicare cost-based organization will not be required to provide coverage for pre-existing conditions for those members (aged and disabled) who do not seek a Medigap policy.

Coverage for pre-existing conditions is limited to those costs related to the pre-existing condition that results in Medicare cost-sharing amounts, such as Part A and B deductibles and coinsurance and excess part B charges, up to the limiting charge.

The Medicare cost-based organization may require all disabled members go to its physicians for treatment, during the time the organization is providing coverage for the pre-existing condition. The Cost-Based organization must coordinate and track these beneficiaries during the enrollment period and during the time they are receiving services. CMS must be able to track compliance.

Special rules apply for affected beneficiaries in a managed care trial period. These individuals must actively and voluntarily disenroll from their non-renewing Medicare cost-based organizations in order to choose from a broader range of Medigap policies available on a guaranteed issue basis. Medicare cost-based organizations must provide these beneficiaries with written documentation of their voluntary disenrollment, even if the voluntary request is for a December 31, 2009 effective date. Beneficiaries may be required to submit this written documentation to a Medigap issuer as proof of their right to buy certain Medigap policies on a guaranteed issue basis. CMS Model Letters for Voluntary Disenrollmentare found in the Medicare Managed Care Manual, on CMS’ website at <http://www.cms.hhs.gov/MedicareMangCareEligEnrol/Downloads/DraftMAEnrollmentGuidanceUpdate2010.pdf>.

### *Public Notice of Non-Renewal for both MA, MA-PD and Cost-Based Organizations*

The Model Public Notice is at the end of this guidance. Non-renewing MA and MA-PD organizations must publish a public notice of non-renewal at least 60 days prior to the end of the contract year (i.e., November 2, 2009). Non-renewing cost-based organizations must publish a public notice at least 30 days prior to the end of the contract, that is, by December 1, 2009. CMS requires MA, MA-PD and Cost-Based plans non-renewing contracts and service area reductions that have more than five (5) percent of MA enrollees in a local community publish a general public notice. The publication of the public notice must be in one or more newspapers of general circulation in each community or county in the non-renewing contract areas. CMS will provide a Model Public Notice of Non-Renewal for all organizations. MA and cost-based organizations that use the CMS Model Public Notice of Non-Renewal without revision are not required to submit the notice to their CMS ROs for review and approval prior to release. However, these MA and cost-based organizations must inform their ROs of the date the notice will be published and, within 5 days after publication, submit a photocopy or clipping of the notice(s) containing the name of the newspaper(s) and publication date. CMS will enter the date of the public notice in the HPMS system.

MA and cost-based organizations that revise the CMS Model Public Notice of Non-Renewal must submit the notice to their RO for review and approval prior to its release for publication. CMS expects this process to take 5 business days. CMS encourages MA organizations to consider this review period when they make plans to meet the November 2, 2009 and/or the December 1, 2009 public notice deadline.

All beneficiary notices, including the Model Public Notice for Part C Non-Renewing Contract and Service Area Reductions, must be reviewed and approved by the appropriate CMS Regional Office (RO) prior to release. These notification notices must be entered into HPMS. Plans may not modify the model Public Notice for Part C Non-Renewing Contract and Service Area Reductions. The model Public Notice is at the end of the guidance.

If you have questions or concerns about accessing this module, please contact the HPMS help desk at 1-800-220-2028 or [HPMS@cms.hhs.gov](mailto:HPMS@cms.hhs.gov). Be sure to include your user ID. Questions about non-renewals may be directed to your Regional Office Account Manager.

### *B. “Close-Out” Information*

### In early-winter of 2009, CMS will provide a “close-out” letter to non-renewing organizations with complete details regarding their obligations after non-renewal. These instructions are to ensure that affected beneficiaries experience a smooth transition to another health coverage option and define those tasks that the organization must perform after the last day of its contract.