

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



CENTER FOR DRUG AND HEALTH PLAN CHOICE

DATE: November 12, 2009

TO: All PDP, MA-PD, MA, CCP, PFFS, RPPO, MSA, HCPP, Employer/Union-Only Group Waiver Plans (EGWP) and Cost-Based Organizations with Contracts that will Terminate or Non-Renew in 2009

FROM: Thomas Hutchinson, Director
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RE: Close-Out Letter for Organizations with a Contract that Ends in 2009

The purpose of this communication is to provide post-contract termination requirements for all PDP, MA-PD, MA, CCP, PFFS, RPPO, MSA, HCPP, EGWP, and cost-based organizations that have a contract that will end at the close of 2009. The close-out letter that follows is divided into two subject areas: Payment and Additional Part C and Part D Specific Requirements. Please follow the applicable instructions for your organization type. If you have any questions, please contact the specialist listed in the letter for that subject area. Again, these instructions are only applicable for contracts that terminate or non-renew prior to January 1, 2010.

Thank you.

Close-Out Letter

The following are post-contract termination requirements which all organizations that have a contract that ends at the close of 2009 are responsible for beyond December 31, 2009.

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. Non-renewing organizations are required to submit all risk adjustment data to CMS as follows: 1) January 2008 through December 2008 dates of service must be submitted by January 31, 2010; and 2) January 2009 through December 2009 dates of service must be submitted by March 5, 2010. For non-renewing organizations, March 5, 2010 will be the final risk adjustment data submission deadline for reporting diagnoses for 2009 dates of service. 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 are currently required to submit prescription drug event data (PDE) and direct and indirect remuneration (DIR) to CMS. In accordance with section 1.4.1 of the Instructions-Requirements for Submitting Prescription Drug Event Data, non-renewing organizations must submit PDE records “to CMS electronically at least once a month. Throughout the coverage year, CMS will monitor plan data submission levels to detect plans with submission volumes lower than expected.” In accordance with section 1.4.2 of the Instructions-Requirements for Submitting Prescription Drug Event Data non-renewing organizations must submit all PDE data to CMS by the final submission deadline, which is May 31, 2010. In accordance with 42 CFR § 423.336(c)(1), non-renewing organizations are required to submit the DIR Report for Payment Reconciliation by June 30, 2010. Non-renewing plans should reference the Final Medicare Part D DIR Reporting Requirements for Payment Reconciliation for 2009, which CMS will release in the spring of 2010. Please note that the data submission deadlines for both PDE data and DIR data apply to all plans, not just terminated plans. CMS reserves the right to extend those deadlines based on operational considerations. In accordance with 42 CFR § 423.505(k)(5), non-renewing organizations are also required to submit “the Attestation of Data Relating to CMS Payment to a Medicare Part D Sponsor”, prior to the 2010 Part D Payment Reconciliation. In submitting this attestation, MA-PD and PDP organizations 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 should reference 2009 guidance regarding the submission of this attestation, which CMS will release via HPMS in the summer of 2010.

(3) **Retroactive Adjustments for Payment and Enrollment:** In accordance with section 70.2 of Chapter 11 of the Medicare Managed Care Manual, non-renewing organizations 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 December 22, 2009). Organizations must confirm those corrections on the February reports 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 for 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 is completed for 2009.

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 2009 is performed), after the end date of your contract, December 31, 2009. 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 that are also reducing service areas for contracts that will continue in 2010, 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 2010.

(4) Disenrollment Transaction Processing:

For the most part, terminating organizations do not need to submit disenrollment transactions and beneficiaries do not need to request disenrollment, except as described below. Non-renewing plans are required to submit disenrollment transactions for members who wish to disenroll prior to the non-renewal date, (i.e. effective December 1, 2009), according to the usual disenrollment request processing requirements as provided in CMS Enrollment guidance. This must be accomplished while your plan still has access to CMS systems so the disenrollments are processed.

Additionally, MARx monthly reports will no longer be available 61 days after an organization terminates. Copies of MMRs created after that date will accompany a terminated organization's final reconciliation results from CMS.

(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 terminated. If access to CMS systems is required for your contract after 60 days, please contact Marla Kilbourne at Marla.Kilbourne@cms.hhs.gov. If inactive plans 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 442 CFR § 422.505(b), and for Part D 42 CFR § 423.104(a) and 442 CFR § 423.506(b)) to provide their enrollees with benefits for the full 12-month term (January 1, 2009 through December 31, 2009) of their sponsor contract with CMS. Consequently, non-renewing organizations must fully honor claims related to covered services provided to their members

during the 12-month term but received after the close of the contract year, in accordance with the applicable contract terms.

(7) **1876 Cost-Based Plans:** CMS requires all terminated 1876 Cost-Based Plans to submit a final cost report by June 30, 2010. All terminating cost plans will be audited and the plans should keep all records and documentation necessary to support costs reported on their final and open year cost reports.

For any questions related to this section, please contact Deondra Moseley at Deondra.Moseley@cms.hhs.gov.

Additional Part C and Part D Requirements

(1) **Corrective Action Plans (CAP):** Organizations currently operating under a corrective action plan must continue to fulfill the requirements of the CAP through December 31, 2009, unless CMS informs otherwise.

(2) **HEDIS/CAHPS:** Non-renewing MA organizations will not be required to submit HEDIS 2011 data (i.e., HEDIS results from the 2009 measurement year) or participate in CAHPS 2011. (*HEDIS does not apply to PDPs.*)

(3) **Quality Improvement Projects (QIP and Chronic Care Improvement Program (CCIP):** MA organizations are required by regulation and contract to perform annual Quality Improvement Projects, which generally run on a three-year cycle, and to implement a Chronic Care Improvement Program. Both require periodic reporting at the request of CMS. CMS will not require non-renewing organizations to report this information. (*This does not apply to PDPs.*)

(4) **Maintenance of Records:** In accordance with 42 CFR § 422.504 (d) and (e) and § 423.505 (d) and (e), organizations are required to maintain and provide CMS access to its records. Specifically, organizations 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 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 non-renewing organization 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 non-renewing organization is responsible for the covered charges through the last day of its contract or, for organizations reducing their service area, the last day which was part of the approved service area in a particular county.

With respect to enrollees receiving care in a skilled nursing facility (SNF), non-renewing MA organizations are financially liable for care through December 31, 2009. 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 PDPs.***)

(6) **Pending Appeals:** Part C and Part D appeals decided in favor of the appealing party after the date that the organization's contract terminates must be effectuated by the (former) organization 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 its 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 and Part D organizations are obligated to effectuate appeals decided in favor of the appealing party after the date that the organization's contract terminates.

(7) **Reporting Requirements:** Non-renewing organizations are required to fulfill all Part C and Part D reporting requirements. Data that are due after the contract year must be submitted. Please refer to the Part C and Part D Reporting Requirements documents for specific deadlines for each section.

(8) **Data and Files:** Non-renewing organizations are required to adhere to 42 CFR § 423.507(4) (a). This regulation requires non-renewing Part D plan sponsors to ensure the timely transfer of any data or files. (***This requirement applies to Part D plan sponsors only.***)

For questions in this section related to Part C requirements, please contact Ann Moses at ann.moses@cms.hhs.gov, and for questions related to Part D requirements, please contact Rochel Schnur at rochel.schnur@cms.hhs.gov.