70.2 - Responsibilities of Nonrenewing MA Organizations

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MA organizations non-renewing their MA contracts must continue to meet the following requirements through the remainder of their final contract year.

1. **Financial Audits -** CMS is required by statute to audit at least one-third of MA organizations' financial records each year. Such records include all pertinent financial records (including data relating to Medicare utilization, costs, and development of the bid). Therefore, those audits started for the current year must

be completed. This will assure that Medicare beneficiaries received appropriate benefits at proper price levels.

2. **Corrective Action Plans (CAP) -** MA organizations operating under a corrective action plan must continue to fulfill the requirements of the plan through December 31 of the final contract year.

3. **Health Employer and Data Information Set (HEDIS®) / Consumer Assessment of Health Plans Study (CAHPS) -** Non-renewing MA organizations will not be required to submit HEDIS® data results from their final MA contract year. (For example, MA organizations non-renewing their MA contract January 1, 2001, would not be required to submit HEDIS® results from the year 2000 measurement year.) Non-renewing MA organizations are similarly not required to participate in the CAHPS survey for the final year of their MA contract by submitting names and telephones numbers for telephone follow-up on non-respondents.

4. **Physician Incentive Plan (PIP) Requirements -** Non-renewing organizations must continue to provide assurances satisfactory to CMS that they are meeting the requirements specified at §422.208 and must continue to disclose to beneficiaries who request it the information specified AT §422.210. Organizations with incentive arrangements at substantial financial risk must assure that physicians have adequate stop-loss protection.

5. **Quality Improvement) -** MA organizations are required by regulation and contract to operate quality improvement programs as specified in 42 CFR 422.152 of the regulations and Chapter 5 of the manual. These requirements include chronic care improvement programs, quality improvement projects as well as measuring performance, and reporting on performance, as requested.

    - For Projects in Their Third Year - During the MA organization's final contract year, the MA organizations must complete the project data collection and continue any quality improvement initiatives;

    - For Projects in their Second Year (unless the second year of a Quality Improvement project is the project's completion year) - During the MA organization's final contract year, the organization must continue its quality improvement initiatives but need not continue data collection; and

    - For Projects in Their First Year - During the MA organization's final contract year, the organizations may discontinue the project altogether. However, if a health care intervention has been started designed to improve the health status of enrollees, the MA organization must continue to provide that care until the actual end of the MA contract.

The following are MA requirements for which non-renewing organizations remain responsible beyond December 31 of the final contract year:

1. **Maintenance of Records -** MA organizations are required to maintain and provide CMS access to books, records, and other documents related to the

operation of an MA contract. Under 42 CFR 422.504(d) and (e), MA organizations are to maintain these records, and allow CMS access to them, for 10 years from the termination date of the contract or the date of the completion of any audit. In the case of service area reductions, MA organizations must maintain these records, and allow CMS access to them, for 10 years from the date from which service in a particular county was discontinued. This also includes contract terminations that result from a decision by an MA organization not to renew its MA contract with CMS.

2. **Continuation of Care -** Terminating MA organizations and those plans reducing their service areas may, in certain situations, be responsible for costs incurred for Medicare beneficiaries hospitalized beyond the last day of the contracts. If a Medicare beneficiary is hospitalized in a prospective payment (PPS) hospital, the MA organization is responsible for all Part A inpatient hospital services until the beneficiary is discharged, as stated at 42 CFR 422.318(c). Original Medicare or the beneficiary's next Medicare-contracting managed care organization will assume payment for all services covered under Part B after the terminating MA organization's MA contract ends. If a Medicare beneficiary is in a non-PPS hospital, your organization is responsible for the covered charges through the last day of your contract or, for plans reducing their service areas, the last day in which service in a particular county are discontinued.

   With respect to enrollees receiving care in a skilled nursing facility (SNF) upon the termination of the MA contract, terminating MA organizations are financially liable for such care through December 31 of the final contract year. After that date, Medicare beneficiaries continuing a SNF stay may receive coverage through either fee-for-service Medicare or enrollment in another MA plan. Assuming that the SNF stay is Medicare covered, the number of days of the beneficiary's SNF stay while enrolled in the MA plan will be counted toward the 100-day Medicare limit. For example, if a beneficiary entered a SNF on December 1, 2005, and was disenrolled on December 31, 2005, 31 days of the stay would be covered by the MA organization, leaving 69 days of fee-for-service coverage beginning January 1, 2006. Those beneficiaries who enroll in another MA plan will receive SNF coverage beginning January 1, 2006, according to the CMS-approved benefit package offered by that plan. MA organizations reducing their service areas must apply this SNF coverage policy to their enrollees who reside in the discontinued portion of the service area.

   For more information on the kinds of facilities that trigger the continuation of care provisions see 42 CFR 422.318(a).

3. **Pending Appeals -** The MA contract and the regulations at 42 CFR 422.504(a)(3) require MA organizations to provide access to benefits for the duration of their contracts. Also the language at 42 CFR 422.618(b) requires MA organizations to "pay for, authorize, or provide" the services that the Center for Health Dispute Resolution (CHDR) determines should have been covered by the organization. As such, MA organizations are obligated to process any appeals for services which

would have been provided or paid for while Medicare beneficiaries were enrolled in the plan. Reconsiderations and appeals decided in favor of the Medicare beneficiary after the date that the MA organization's contract terminates are the obligation of the (former) MA organization – regardless of when the decision is effectuated.

4. **Retroactive Payment Adjustments -** For terminating MA organizations, once the MA contract has been terminated and the MA organization is no longer receiving payments from CMS, the organization will still be required to reimburse CMS for any overpayments. Also, the MA organization will still have the right to seek reimbursement from CMS for any previously identified underpayments to the extent permitted by applicable law. MA organizations seeking payment adjustments should report corrected information within 45 days of the contract termination date to the CMS contractor responsible for retroactive payment adjustment data processing. These data include, but are not limited to, adjustments based on changes to enrollments, Medicaid status, and institutional status for Part C demographic payment which date from the period during which the contract was effective. The reporting of corrected information will trigger the CMS retroactive payment adjustment process. The reported corrections will be verified and applied to your (former) members' records. These corrections will be included as a part of your final payment reconciliation.

   CMS will complete final reconciliation of its accounts with the MA organization within approximately nine months of the termination date of the MA contract. However, it is important to note that completion of final reconciliation may be delayed in the event that the organization fails to comply with remaining data submission requirements.