DEPARTMENT OF HEALTH & HUMAN SERVICES
Centers for Medicare & Medicaid Services
7500 Security Boulevard, Mail Stop C4-21-26
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TO: Medicare-Medicaid Plans

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SUBJECT: Close-Out Letter for Medicare-Medicaid Plan sponsors that are Non-Renewing effective January 1, 2026

This guidance provides close-out requirements for all Medicare-Medicaid Plan (MMP) contracts that are non-renewing on or before **January 1, 2026**. The memorandum contains your organization's obligations to the Centers for Medicare & Medicaid Services (CMS). Separate close-out instructions may also be issued from your respective state Medicaid agency.

These instructions are divided into two subject areas: "Payment" and "Additional MMP and Part D Requirements."

Payment

Risk Adjustment Data: MMPs are required to submit risk adjustment data and attestations to CMS and your respective state Medicaid agency for its non-renewing contracts. Risk adjustment data includes both Risk Adjustment Processing System (RAPS) and Encounter Data System (EDS) data. The due dates are as follows:

a. January 2024 through December 2024 dates of service must be submitted by the final payment year (PY) 2025 risk adjustment data submission deadline, as announced via HPMS memorandum, or before the contract loses access to CMS systems, whichever happens first; and
b. January 2025 through December 2025 dates of service must be submitted before the contract loses access to CMS systems.

For any questions related to risk adjustment data or submission deadlines, please email: riskadjustmentpolicy@cms.hhs.gov. For any questions related to the operational submission of RAPS or encounter data, please email: riskadjustmentoperations@cms.hhs.gov.

Prescription Drug Data and Direct and Indirect Remuneration Data: MMPs are required to submit to CMS contract-specific prescription drug event (PDE) data and direct and indirect remuneration (DIR) data. In accordance with section 1.4.1 of the Instructions-Requirements for Submitting Prescription Drug Event Data,[1] MMPs must submit PDE records "to CMS electronically at least once a month." In accordance with the May 16, 2011, HPMS memorandum titled, "Timely Submission of PDE Records and Resolution of Rejected PDEs," and the subsequent revision to the memorandum released through HPMS on October 6, 2011, MMPs must submit original PDE records to CMS within 30 days following the "Date Claim Received" or "Date of Service" (whichever is greater). MMPs 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. MMPs with non-renewing/terminating contracts must submit all 2025 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 2025 PDE records, the deadline will be 11:59 PM ET, June 29, 2026. PDEs submitted after the deadline will not be considered in the 2025 Part D payment reconciliation.

In accordance with the regulations (42 CFR §§ 423.336(c)(1) and 423.343(c)(1)), MMPs with non-renewing/terminating contracts are required to submit the 2025 DIR Report for Payment Reconciliation corresponding to these contracts by June 30, 2026. Non-renewing MMPs should reference the Final Medicare Part D DIR Reporting Guidance for 2025, which CMS will release in the spring of 2026.

[1] Available at https://www.csscoperations.com/internet/csscw3.nsf/DIDC/GZEB9OUQJ9~Prescription%20Drug%20Program%20(Part%20D)~References

Please note that the data submission deadlines for both PDE data and DIR data apply to all organizations/sponsors, not just non-renewing MMPs. CMS reserves the right to adjust these deadlines based on operational considerations.

In accordance with the regulations (42 CFR § 423.505(k)(3) and (5)), MMPs with non-renewing contracts, are required to submit "the Attestation of Data Relating to CMS Payment to a Medicare Part D Sponsor" and "the Attestation of Data Relating to Detailed DIR Report" prior to the 2024 Part D Payment Reconciliation. In addition, MMPs submit the "Attestation of Plan-to-Plan (P2P) Reconciliation Payment Data" attesting to compliance with 42 CFR § 423.464(a). Non-renewing MMPs should reference 2024 guidance regarding the submission of these attestations, which CMS will release via HPMS in the summer of 2025.

Questions regarding DIR submission may be emailed to: DIR_Reporting_Reqts@cms.hhs.gov. Questions regarding PDE submission may be emailed to: PDE-Operations@cms.hhs.gov. Questions regarding attestations related to PDE data, DIR data, and P2P data may be emailed to PDE_DIR_Attestations@cms.hhs.gov.

Medical Loss Ratio: MMPs with non-renewing contracts are required to submit the annual Medical Loss Ratio (MLR) Report and Attestation to CMS in a manner consistent with the three-way contract. CMS and your respective state Medicaid agency will communicate due dates for the outstanding MLR Reports and Attestations.

Questions regarding MLR may be emailed to: MMCOCapsModel@cms.hhs.gov.

Overpayments: MMPs are required to adhere to section 1128J(d) of the Social Security Act, overpayment regulations (42 CFR § 422.326 and § 423.360, and the three-way contract), and all other data accuracy requirements. These provisions require that an MMP report and return overpayments to CMS and your respective state Medicaid agency, and these requirements continue after a contract is non-renewed.

Risk adjustment related overpayments (in both RAPS and EDS) identified by non-renewing/terminating contracts must be reported to CMS in the Risk Adjustment Overpayment Reporting (RAOR) module in HPMS and include an auditable estimate of the overpayment amount (including how the estimate was derived) and the reason for the overpayment. When asked the reason the data is not available to submit, include the phrase "terminating contract" along with any other relevant information in the response.

Questions regarding the risk adjustment overpayment process may be emailed to: riskadjustmentpolicy@cms.hhs.gov. Questions regarding PDE or DIR corrections may be emailed to: PDE-Operations@cms.hhs.gov.

Access to the Health Plan Management System: MMPs may retain access to HPMS in order to perform reporting functions (e.g., DIR, MLR, risk adjustment overpayments, cost reports, and complaint resolution) that continue after the CMS contract has ended. Users must complete the annual user recertification process and maintain their password to retain their CMS user ID.

Retroactive Payment Adjustments: MMPs that need to submit retroactive enrollment or disenrollment transactions, and State and County Code changes that can cause a retroactive payment

adjustment after non-renewal should submit corrected information to the Retroactive Processing Contractor (RPC) within 90 days from the date of its last MARx monthly payment reports. The requested corrections will be verified and once verified, applied to the Plan's member records. Payment adjustments calculated based on information updated by the RPC will be included in the Plan's final settlement payment.

Final Settlement: CMS's final settlement process lasts for a minimum of 18 months, after the end of the calendar year the contract ended with CMS. As part of the final settlement process, it is important for MMPs to understand that all applicable reconciliations must process before CMS will officially calculate, disburse, or collect any final settlement payment. Therefore, no payment disbursements or collections will occur between any reconciliation. These reconciliation processes include:

1) 2025 Final Risk Adjustment reconciliation;
2) 2025 Part D annual reconciliation;
3) 2024 Coverage Gap Discount Program annual reconciliation;
4) 2025 Manufacturer Discount Program annual reconciliation; and
5) 2024 and 2025 Medicare A/B Quality Withhold payments.

Additionally, the following are included by state:

- Illinois, Michigan, Ohio, Rhode Island, South Carolina: 2024 and 2025 MLR remittance;
- Illinois: 2023 MLR remittance
- Massachusetts: 2022 through 2025 Risk Corridor settlements;
- New York: 2022 and 2023 Risk Corridor settlements; and 2020 through 2025 MLR remittance;
- Michigan: 2022 and 2023 MLR remittance
- Ohio: 2022 and any 2025 Risk Corridor settlements;
- Rhode Island: 2023 MLR remittance;
- South Carolina: 2023 MLR remittance; and
- Texas: any outstanding STAR+PLUS MMP-specific Experience Rebate payments; and any outstanding Medicare A/B quality withhold payments.

For contracts ending in 2025, MMPs can expect to receive a final settlement package from CMS after July 2027, explaining whether the MMP will receive or owe CMS a settlement payment. In part of delivering the final settlement package to the MMPs, CMS will include all the Monthly Membership Reports (MMRs) created from the time the contract ended until the month the final settlement was processed. These reports will include details for retroactive payment adjustments that accumulated after the contract ended.

However, it is important to note that MMPs that fail to comply with its remaining data submission requirements may delay the receipt of their final settlement payment.

Questions regarding the final settlement process may be emailed to: James.Krall@cms.hhs.gov.

Please note that your respective state Medicaid agency may issue additional final reconciliation guidance.

Claims: MMPs are required by (42 CFR §§ 417.407(f), 417.416(a), 417.416(e), 417.800(a)(2), and 417.801(c)) to provide their enrollees with benefits for the full term of their contract with CMS. Consequently, MMPs (including those with non-renewing contracts) must fully honor claims related to covered services and prescriptions provided to their enrollees during the term of their contract.

True Out-of-Pocket (TrOOP) Balance Transfer: MMPs 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 TrOOP balance process and timeliness to be a part of these requirements. MMPs 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.

As of 2017, the automated transfer of TrOOP accumulator data includes the full 36-month coordination of benefits period (3 years prior to the current plan year). 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 all years included in this extended time period. Therefore, MMPs must ensure that their FIR processors are contracted to handle transactions for the current and prior years covered under the enhanced ATBT process. For some MMPs, this may entail re-contracting with a former processor to process prior year FIR transactions.

Additional MMP and Part D Requirements

Corrective Action Plans: MMPs remain obligated to comply with all Part C, Part D, and MMP demonstration requirements during the close-out of their contracts and to fully address any areas of non- compliance identified by CMS or your state Medicaid agency that remain outstanding, as of the contract termination date.

Healthcare Effectiveness Data and Information Set/Consumer Assessment of Healthcare Providers and Systems/Health Outcomes Survey: MMPs with non-renewing contracts will be required to submit Healthcare Effectiveness Data and Information Set (HEDIS) data in 2026 for those contracts (i.e., HEDIS results from the 2025 measurement year). Non-renewing MMPs will not be required to submit HEDIS patient-level data (PLD). However, in the event HEDIS PLD are required, CMS will provide instructions on the data submission. MMPs with non-renewing contracts will not be required to participate in the Health Outcomes Survey (HOS) baseline and follow-up surveys administered in 2026. Further, non-renewing MMPs are not required to participate in the Consumer Assessment of Healthcare Providers and Systems (CAHPS) survey administered in 2026; however, MMPs that transition to integrated D-SNPs as of 1/1/2026 may voluntarily elect to conduct the CAHPS survey in 2026 . Integrated D-SNPs that choose to

voluntarily conduct the CAHPS survey in 2026 but are not otherwise eligible for the survey will not have their CAHPS data included in the 2027 Part C and D Star Ratings. Integrated D-SNPs choosing voluntary implementation of the 2026 CAHPS survey should follow the instructions and deadlines in the 2026 Medicare CAHPS Survey HPMS memo that will be issued around mid-November.

Chronic Care Improvement Programs: MMPs are required by statute, regulation, and contract to implement Chronic Care Improvement Programs (CCIPs), which require an annual attestation to CMS that the organization has an ongoing CCIP. However, CMS does not require MMPs with non-renewing contracts to provide the annual CCIP attestation in HPMS for the final contract year for those contracts prior to the non-renewal date. Questions regarding CCIPs may be submitted to the Medicare Part C Policy Mailbox, located at: https://dpap.lmi.org.

Continuation of Care: If an enrollee is hospitalized in a prospective payment system (PPS) hospital, the MMP with the non-renewing contract is responsible for all Part A inpatient hospital services until the enrollee is discharged, in accordance with the regulation (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 MMP with the non-renewing contract is responsible for the covered charges through the last day of the contract.

With respect to enrollees receiving care in a skilled nursing facility (SNF), MMPs 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 the MMP will be counted toward the 100-day limit. Questions regarding continuation of care may be submitted to the Medicare Part C Policy Mailbox, located at: https://dpap.lmi.org.

Pending Appeals: MMP Part C and Part D appeals decided in favor of the appealing party, after the date the MMP's contract non-renews, must be effectuated by the (former) MMP in accordance with the regulations and the three-way contract.

The regulations at 42 CFR § 422.504(a)(3) require MMPs to provide access to benefits for the duration of their contracts. Similarly, your three-way contract requires MMP organizations to pay for, authorize, or provide services that an adjudicator determines should have been covered by the organization. Therefore, MMPs are obligated to process any appeals, as governed by 42 CFR Part 422, Subpart M, for services or Part B drugs that, if originally approved, would have been provided or paid for while MMP enrollees were enrolled in their plan. Additionally, the regulations (42 CFR § 422.100(b)(1)(v)) provides MMPs must make timely and reasonable payment to non-contracting providers and suppliers for services which coverage has been denied by the MMP and found upon appeal to be services the enrollee was entitled to have furnished or paid for by the MMP. Similarly, regulation (42 CFR § 423.505(b)(4)) requires MMPs provide access to benefits for the duration of their contracts. Also, the regulations (42 CFR § 423.636 and § 423.638) require MMPs to authorize, provide, or make payment for a benefit that an adjudicator determines covered by the MMP. Therefore, MMPs 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 enrollees were enrolled in their plan.

In addition, the three-way contract requires MMPs to continue providing benefits for all prior

approved non-Part D benefits that are terminated or modified pending internal MMP appeals.

Customer Service: In order to appropriately comply with claims, appeals and continuation of care requirements, MMPs shall continue to operate customer service lines and maintain websites containing required plan communications, like the Evidence of Coverage. Please refer to regulations at 42 CFR §§ 422.111(h)(1) and 423.128(d)(1) for customer service call center days and hours of operation requirements.

Core and State-Specific MMP Reporting Requirements: Unless otherwise specified in writing by CMS in a subsequent letter, MMPs with non-renewing contracts will be required to submit all quality measures required for participation in your Demonstration. This includes measures outlined in the Calendar Year 2025 Medicare-Medicaid Capitated Financial Alignment Model Core Reporting Requirements, and your state-specific Reporting Requirements. MMPs will report all measures covering their performance from January 1, 2025 through December 31, 2025, including measures due after December 31, 2025 for which some or all of the period of performance is prior to December 31, 2025.

Part C and Part D Reporting Requirements: MMPs must report data to CMS per the Part C and D reporting requirements (42 CFR §§422.516(a) and 423.514(a)) and conduct annual, independent data validation of these data per the specifications developed by CMS (42 CFR §§422.516(g) and 423.514(j)). MMPs that non-renew or terminate during the measurement year or prior to the reporting/data validation deadlines are not required to submit the Part C/D reporting requirements data or undergo data validation. Therefore, MMPs with contracts that non-renew in 2025, or prior to July 1, 2026, are not required to submit 2025 Part C/D reporting requirements data (due in 1Q of 2026) or undergo Part C/D data validation of 2025 data (due June 15, 2026).

Data and Files: MMPs with non-renewing contracts are required to adhere to the regulation (42 CFR § 423.507(a)(5)) that requires MMPs with non- renewing contracts to ensure the timely transfer to CMS of any data or files.

Health Plan Management System Complaint Tracking Module: MMPs with non-renewing contracts are required to document, resolve, and close out all complaints received via the Complaint Tracking Module related to events that occurred prior to the end of the contract term, in accordance with CMS guidance and instructions.

Part D Drug Management Program/Overutilization Monitoring System: Consistent with 42 CFR §§423.153(f)(1)(iii) and 423.153(f)(15)(ii)(E), MMPs must transfer case management information when requested by a gaining Part D sponsor for potential at-risk beneficiaries and at-risk beneficiaries who disenroll from the MMP's plan with a drug management program (DMP) coverage limitation that had not terminated before disenrollment.

Maintenance of Records: MMPs are required by regulation (42 CFR §§ 422.504(d) and (e) and 423.505(d) and (e)) and the three-way contract to maintain and provide CMS access to their records. Specifically, MMPs must maintain books, records, documents, and other evidence of accounting procedures and practices for ten (10) years. These regulations also detail the requirements for government access to an MMP's facilities and records for audits that can extend through ten (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 service area that was reduced start on the date the particular county or counties were removed from the service area.

Thank you for your attention to these matters. If you have any questions, please contact the Medicare-Medicaid Coordination Office at MMCOcapsmodel@cms.hhs.gov.