

Department of Health & Human Services  
Centers for Medicare & Medicaid Services  
Jacob K. Javits Federal Building  
26 Federal Plaza, Room 3810  
New York, NY 10278



**New York Regional Office**

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**AD HOC CORRECTIVE ACTION PLAN**

**December 26, 2013**

H4005, H4012, H5732

Ms. Mercedita Montalvo  
Chief Compliance Officer  
American Health, Inc.  
P.O. Box 11320  
San Juan, PR 00922

VIA EMAIL: [mmontalvo@ahmpr.com](mailto:mmontalvo@ahmpr.com)

**RE: Failure to Adhere to Provider Credentialing Requirements**

Dear Ms. Montalvo:

The Centers for Medicare & Medicaid Services (CMS) is issuing this Ad Hoc Corrective Action Plan (CAP) to Triple S Salud, Inc.(Triple S), which operates Medicare Advantage-Prescription Drug contracts (H4005, H4012, H5732), for its failure to comply with Part C requirements related to the credentialing and re-credentialing of contracted providers. Specifically, Triple S failed to fulfill credentialing requirements of its contracted provider network offered under Medicare Advantage Prescription-Drug Plan (MA-PD) sponsor contracts mentioned above. As a result, CMS directs Triple S to take corrective action to address the identified areas of non-compliance.

Pursuant to 42 C.F.R. §422.204(b) and the Medicare Managed Care Manual Chapter 6, Section 60.3, MA organizations must follow a documented process for providers who have signed contracts with the organization. This credentialing requires the MA organization to verify licensure or certification from primary sources, disciplinary status, eligibility for payment under Medicare, as well as conducting site visits. MA organizations must re-credential providers at least every three years.

In January 2013, Triple S Management notified CMS that they identified failures in their credentialing and re-credentialing process. Furthermore, Triple S reported that approximately 10,550 providers, providing services to 70,000 members, were not appropriately credentialed or re-credentialed. At that time, Triple S provided CMS a corrective action plan that included (1) a root cause analysis and (2) a work plan with remedial steps to resolve the credentialing and re-credentialing issues. Triple S' plan provided for credentialing compliance by October 31, 2013.

Since the January 2013 notification, CMS has been working with Triple S to assist them with coming into compliance. CMS provided technical assistance to the plan sponsor related to process improvement and remediation on a regular basis. This included conference calls, provider files review, and regulation interpretation. During this time, Triple S continued to inform CMS that they were on target to complete the credentialing process by the end of October. In September 2013, CMS once again inquired of Triple S if they would be able to complete the credentialing project by proposed date. Triple S advised CMS of its inability to complete the credentialing process for its contracted provider network by October 31, 2013.

Triple S' failure to ensure providers are properly credentialed has resulted in beneficiaries potentially receiving care from unlicensed providers, receiving care from providers banned from Medicare or receiving care from providers who have malpractice issues. Triple S' failure to ensure providers are properly credentialed has the potential of serious beneficiary harm. Based on the above information, CMS has determined that Triple S failed to comply with the requirements at 422.204(b).

CMS requests that Triple S submit to CMS a detailed Corrective Action Plan (CAP) by **January 24, 2014** to Militza Flores, Account Manager at [militza.flores@cms.hhs.gov](mailto:militza.flores@cms.hhs.gov). As part of this CAP, Triple S should address the actions listed below, plus any other additional items that Triple S identifies as necessary to correct this problem and prevent it from reoccurring. Because of the complexity and sensitivity of this matter, CMS will review materials and intermediary implementation steps throughout the process. Further, our engagement throughout this process will provide CMS with the information we need to eventually close the CAP.

- Provide to CMS a detailed and updated root cause analysis as well as a member impact analysis.
- Submit revised credentialing and re-credentialing policies and procedures, including a work plan that delineates manner and frequency such policies and procedures will be revised.
- Submit evidence of staff training and training materials.
- Current Work Plan that includes entire provider network credentialing completion date.
- Schedule of internal monitoring and auditing activities specifically for credentialing and re-credentialed providers' files that will be performed as part of Triple S Compliance Program for the remainder of CY2013 and for the entire CY2014.
- Fully implement any necessary quality improvement activities to ensure the non-compliance will not reoccur.

CMS is issuing this compliance notice pursuant to 42 C.F.R. §422.510(c), which requires CMS to afford a sponsor at least 30 days to develop and implement a corrective action plan to correct deficiencies before taking steps to terminate a sponsor's Medicare contract. While CMS is not obligated to grant a greater than 30-day cure period, we acknowledge that an extended period may be appropriate, depending on the nature of the correction required. CMS advises that, for any part of its timeline scheduled to be completed in more than 30 days, Triple S provide a justification of the need for that additional time. CMS expects that the correction timeline will be no longer than absolutely necessary and will reflect an appropriate level of urgency in resolving this matter.

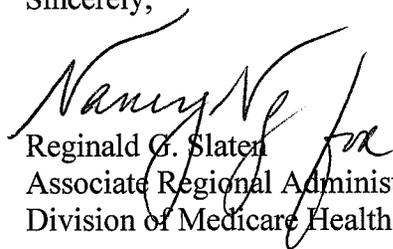
CMS has the authority to impose sanctions, penalties and other enforcement actions as described in Federal regulations at 42 CFR 423 Subpart O. Should your organization fail to develop,

implement or complete its CAP, CMS may consider the imposition of intermediate sanctions (e.g., suspension of marketing and enrollment activities) or civil money penalties.

Please be aware that this letter will be included in the record of your organization's past Medicare contract performance, which CMS will consider as part of our review of any application for new or expanded Medicare contracts your organization may submit. This letter is considered a Part C issue with beneficiary impact for past performance purposes. In determining the severity of this notice, CMS has considered as a mitigating factor your organization's efforts in self-reporting information concerning the non-compliant activity

If you have any questions about this letter, please contact your Account Manager, Militza Flores, at (787) 294-1606.

Sincerely,



Reginald G. Slaten  
Associate Regional Administrator  
Division of Medicare Health Plans Operations

cc via email:

Militza Flores, Account Manager, RO II  
Christine Reinhard, Part C Compliance Lead  
Rachel Walker, Division Director, CMHPO, ROII