



CENTER FOR MEDICARE

CORRECTIVE ACTION PLAN REQUEST

August 30, 2013

Contract: H5928

Mr. Brooks Jones
Medicare Compliance Officer
Care1st Health Plan
601 Potrero Grande Drive
Monterey Park, CA 91755

Delivered via e-mail to: bjones@care1st.com

Re: 2013 Plan Correction

Dear Mr. Jones,

The Centers for Medicare & Medicaid Services (CMS) is issuing a request for a Corrective Action Plan (CAP) to Care1st Health Plan (hereinafter "Care1st"), regarding its performance under the Medicare Advantage Prescription Drug (MA-PD) contract identified above, because it failed to adhere to the CMS requirement that Part D sponsors' final contract year (CY) 2013 bid submission and certifications are complete and accurate at the time of submission.

In the 2013 Call Letter released on April 2, 2012, via the Health Plan Management System (HPMS) and in an HPMS memo released on May 11, 2012, entitled *Release of Contract Year (CY) 2013 Bid Upload Functionality in HPMS*, CMS provided instructions for submitting bid, initial actuarial certification, and benefit certification information, which was due on June 11, 2012. Federal regulations at 42 C.F.R. § 423.265(c) state that each potential Part D sponsor must submit bids (and supplemental information specified by CMS) that reflect the features (e.g., premium amount, cost sharing) and projected cost estimates of each benefit package it expects to offer. For CY2013, sponsors provided their bid information through three different submissions – a proposed formulary submitted by April 16, 2012 and a Bid Pricing Tool (BPT) and Plan Benefit Package (PBP) submitted together by the statutory June 4, 2012 deadline. Generally speaking, the PBP describes the structure of a proposed benefit package (e.g., co-pay amounts, deductibles) while the BPT describes the underlying basis used to calculate the price of the benefit package. Throughout the Bid Pricing Tool (BPT), which sponsors must submit as part of their annual bids, CMS reminded sponsors of the need to base their bids on accurate information. The information in all three of these submissions must combine to reflect a consistent benefit package. Additionally, pursuant to 42 C.F.R. § 423.505(k)(4), the sponsor's CEO or CFO must

submit a certification (referred to as the “benefit certification”) that the information provided in each bid is accurate, complete, and truthful.

On June 22, 2012, Care1st notified CMS via email that Care1st had submitted a five-tier formulary during the formulary submission window instead of the six-tier formulary it needed to accommodate the supplemental benefits it planned to offer, in the form of coverage of excluded Part D drugs, as part of the benefit package. Care 1st intended the sixth tier to be an excluded drug-only tier where the cost sharing associated with those drugs would be indicated. Care1st wanted to use the six-tier formulary and attempted to remedy this issue during the submission of its initial CY2013 plan benefit package (PBP) by submitting a six-tier formulary model. However, the Plan Benefit Package (PBP) tool disallowed this submission since it was inconsistent with the original five-tier formulary submission. Care1st subsequently changed its PBP submission to a five-tier model and included its excluded drug benefit on tier 4. Care1st then attempted, incorrectly, to use the “Rx notes” section of the PBP to define its copayment structure for the excluded drugs that resided on tier 4. However, an automated restriction that limits the number of characters in the notes field prohibited the organization from accomplishing this.

Following a conference call with CMS on June 27, 2012, Care1st submitted a request to correct (a “plan correction”) both the CY2013 Formulary Tier and PBP Models to include a sixth tier which it would use for its excluded drug benefit. In order to allow the plans to provide a distinct cost-sharing benefit for the excluded drug offering as priced in the original BPT, CMS granted Care1st’s request.

On July 3, 2012, Care1st informed CMS that it wanted to revert back to a 5 tier formulary and remove the excluded drug coverage from its plans, a significant proposal tantamount to changing its bid. This proposal to revert to the original five-tier model was made after Care1st determined that the six-tier model change it had requested, which was subsequently implemented by CMS, would apply uniformly to all of the plans associated with that formulary ID, an outcome not intended by Care 1st. As a direct result, Care1st once again encountered issues with uploading the PBPs for the plans that did not offer any excluded drug benefit and, therefore, required a different model. Care1st requested that CMS make a second correction to the same formulary ID and asked for permission to revert back to the original five-tier model and to remove the excluded drug benefit entirely for the plan associated with H5928. Again, CMS granted Care1st’s request.

The initial actuarial certification and benefit certification served as documentation that your organization verified its bid submission. Yet, the need for a plan correction indicated the presence of inaccuracies and/or incompleteness of the bid and calls into question your organization’s ability to submit correct bids and the validity of the final actuarial certification and bid attestation. The plan correction afforded to your organization indicated that your organization failed to comply with Part D regulatory requirements and follow CMS bid instructions.

In addition to the above-described substantive issues, Care1st’s actions were extremely burdensome on CMS. These plan corrections required an inordinate amount of communication

and coordination with Care1st as well as considerable efforts to orchestrate the various tier changes.

In the future, please ensure that your organization submits correct bid information the first time. Should your organization fail to come into compliance in a timely manner, CMS may consider taking enforcement actions in the form of the imposition of intermediate sanctions (e.g., the suspension of marketing and enrollment activities) or civil money penalties or the issuance of a contract termination notice.

Consistent with CMS' authority in 42 C.F.R. §§ 423.507(b)(3) and 423.509(c), we request that your organization develop and implement a CAP designed to ensure that your organization will submit complete and accurate bid submissions and come into compliance with Part D requirements discussed in this letter by the next bid cycle in 2014. CMS will continue to monitor your organization's performance and will consider the CAP closed when it is demonstrated that your organization has come into compliance with the identified program requirement(s).

Please be aware that this CAP request 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. For past performance analysis purposes, this is considered a Part D issue without beneficiary impact. 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 Michael Neuman at (410) 786-7069 or Michael.Neuman@cms.hhs.gov and copy your account manager, Julia Cohen, at Julia.Cohen@cms.hhs.gov.

Sincerely,



Cynthia G. Tudor, Ph.D.
Director
Medicare Drug Benefit and C & D Data Group

CC via email:

Scott Nelson, CMS
Michael Neuman, CMS
Julia Cohen, CMS