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

MEDICARE PARTS C AND D OVERSIGHT AND ENFORCEMENT GROUP

March 28, 2014

E-MAIL: atran@care1st.com

Anna Tran
Chief Executive Officer
Care1st Health Plan
601 Potrero Grande Drive
Monterey Park, CA 91755

Re: 2012 Program Audit – Notice of Audit Closure for Medicare Advantage and/or Standalone Prescription Drug Plan Contracts: H5430 and H5928

Dear Ms. Tran:

On December 5, 2012, the Centers for Medicare & Medicaid Services (CMS) issued the final audit report to your organization for the above-referenced Medicare Advantage and/or Prescription Drug Plan contracts. The audit evaluated your organization's compliance with CMS requirements in the following areas:

1. Part D Formulary and Benefit Administration
2. Part D Coverage Determinations and Appeals
3. Part D Grievances
4. Part C Organization Determinations and Appeals
5. Part C Grievances
6. Part C Access to Care
7. Parts C & D Agent/Broker Oversight
8. Parts C & D Compliance Program Effectiveness
9. Parts C & D Enrollment and Disenrollment
10. Part D Late Enrollment Penalty

Your organization was afforded 90 calendar days from the report date to provide data and documents to CMS to demonstrate and attest that all of the deficiencies in the audit report were sufficiently corrected and not likely to recur. CMS reviewed your evidence of correction submission and also conducted a review to validate the implementation of required corrective actions and immediate corrective actions.

This notice is to inform you that based on the evidence provided by your organization and the validations conducted, you have corrected all conditions except:

The following conditions still remain from the audit report:

1. **Part D Coverage Determinations and Appeals – Effectuation Timeliness, Condition i**. - Care1st did not notify the beneficiary of its determination within 72 hours of receipt of the standard coverage determination request. Additionally, in 1 case reviewed (3), Care1st did not notify the beneficiary of its determination within 24 hours of receipt of the expedited coverage determination request. This condition was not validated as corrected because the same condition was identified in 8 of 13 samples reviewed during the validation (ET-01, ET-02, ET-03, ET-04, ET-05 and ET-12 (expedited); ET-06 and ET-08 (standard)).
2. **Part D Coverage Determinations and Appeals – Effectuation Timeliness, Condition ii. -** Care1st did not auto-forward standard coverage determinations (CD) exceeding the required timeframe to the independent review entity (IRE) for review and disposition. Additionally, in one case reviewed (3), Care1st did not auto-forward the expedited coverage determination exceeding the required timeframe to the IRE. This condition was not validated as corrected because the same condition was identified in 4 of 13 samples reviewed during the validation (ET-01, ET-05, ET-08 and ET-12).
3. **Part D Grievances – Grievances, Condition i. -** Care1st did not follow through to resolve the member's specific complaints before closing. This condition was not validated as corrected because the same condition was identified in 2 of 5 samples reviewed during the validation (GRV-1 and GRV-2).
4. **Part C Organization Determinations and Appeals –Appropriateness of Clinical Decision-Making, Condition iii. -** Care1st's modified approval letter did not include information regarding changes to the requested services or the appeal rights for those services that were not approved. This condition was not validated as corrected because the same condition was identified in 4 of 5 samples reviewed during the validation (CDM-1, CDM-2, CDM-3 and CDM-5).
5. **Part C Grievances – Dismissals, Condition i. -** Care1st submitted the case to the IRE prior to the expiration of the appeal timeframe. This condition was not validated as corrected because the same condition was identified in 3 of 3 samples reviewed during the validation (DIS-1, DIS-2 and DIS-3).

Applicable transition findings were covered by Medicare Drug Benefit and C & D Data Group's (MDBG) Transition Monitoring Program Analysis (TMPA). The results of that analysis and any resulting compliance action(s) will be followed up with by MDBG and your Account Manager.

The following new conditions identified during the validation:

1. **Part D Coverage Determinations and Appeals – Effectuation Timeliness –** Care1st did not effectuate standard and expedited determinations in a timely manner. Care1st does not have an adequate process and effective internal controls to ensure that expedited and standard coverage determination requests are effectuated within the required timeframes. This condition increases the risk that beneficiaries may experience confusion regarding the status of their coverage determinations and/or appeal rights, and could potentially experience a lapse in coverage, a delay in access to care, and/or financial hardship. Care1st must ensure that expedited and standard

coverage determinations are effectuated timely (ET-01, ET-02, ET-03, ET-04, ET-06 and ET-12).

2. **Part C Organization Determinations and Appeals – Appropriateness of Clinical Decision-Making –** When Care1st denied requests for payment from non-contracted providers, the remittance advice notice/Explanation of Benefits (EOB) did not state the specific reason for the denial nor did it provide instructions for appealing through the Sponsor and submitting a Waiver of Liability (WOL). Failure to provide complete notifications regarding the denial of a request for payment may potentially cause financial harm to the beneficiary. Care1st must ensure that all remittance advice notices/EOBs contain the required information, including provider rights for appealing a denied payment request (CDM-6, CDM-8, CDM-ALT-1 and CDM-ALT-2).

Your validation provided CMS with a reasonable assurance you are in compliance with program requirements tested during the audit. However, CMS will require heightened monitoring of the conditions and/or observations noted above to ensure Sponsor continues to implement effective correction. Your Account Manager will contact you to address these issues.

CMS is closing your audit.

CMS considers your compliance program's effectiveness to be essential in preventing, detecting and responding to potential non-compliance and fraud, waste, and abuse. Therefore, CMS expects your organization to continue monitoring the effectiveness of the corrective actions you have implemented and to continue to measure and improve the effectiveness of your compliance program. In addition, your Account Manager will continue to monitor and oversee your operations and compliance program to ensure that your organization is in compliance with all CMS requirements.

If you have any questions concerning this notice, please contact Ms. Julia Cohen at 415-744-4909 or via email at Julia.Cohen@cms.hhs.gov.

Sincerely,

/s/

Tawanda Holmes
Director, Division of Audit Operations
Medicare Parts C and D Oversight and Enforcement Group

cc:
Michelle Turano, CMS/CM/MOEG
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