

DEPARTMENT OF HEALTH & HUMAN SERVICES
Centers for Medicare & Medicaid Services
Center for Medicare
7500 Security Boulevard, Mail Stop C1-22-06
Baltimore, Maryland 21244-1850



MEDICARE PART C & D OVERSIGHT AND ENFORCEMENT GROUP

February 26, 2014

E-MAIL:Ruth.Bauman@atriohp.com

Ms. Ruth Bauman
Chief Executive Officer
ATRIO Health Plans
2270 NW Aviation Drive, Suite 3
Roseburg, Oregon 97470

Re: 2012 Program Audit – Notice of Audit Closure for Medicare Advantage and/or Standalone Prescription Drug Plan Contracts: H3814, H5995, H6743 and H7006

Dear Ms. Bauman:

On February 14, 2013, 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. Enrollment and Disenrollment
10. Late Enrollment Penalty (LEP)

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 – Appropriateness of Clinical Decision Making, Condition i.** - ATRIO's denial letters did not include an adequate rationale or correct information specific to each individual case and did not clearly document next steps to obtain coverage or formulary alternatives in 8 cases. This condition was not validated as corrected because the same condition was identified in 5 of 6 samples reviewed during the validation (CDM-1, CDM-8, CDM-9, CDM-10 and CDM-11).
- 2. Part D Coverage Determinations and Appeals – Appropriateness of Clinical Decision Making, Condition v.** - ATRIO denied coverage determination requests for medication because they did not receive all information needed and there was no documentation of attempts to obtain that information from the prescriber in 11 cases. This condition was not validated as corrected because the same condition was identified in 2 of 6 samples reviewed during the validation (CDM-9 and CDM-10).
- 3. Part D Coverage Determinations and Appeals – Appropriateness of Clinical Decision Making, Condition vi.** - ATRIO denied redetermination requests without sufficient outreach to the prescriber or beneficiary for additional information necessary to make an appropriate clinical decision in 1 case. This condition was not validated as corrected because the same condition was identified in 2 of 5 samples reviewed during the validation (CDM-3 and CDM-4).
- 4. Part D Coverage Determinations and Appeals – Appropriateness of Clinical Decision Making, Condition vii.** - ATRIO did not make standard coverage determination decisions within the required timeframe of 72 hours after receiving the request in 9 cases. This condition was not validated as corrected because the same condition was identified in 4 of 6 samples reviewed during the validation (CDM-9, CDM-10, CDM-14 and CDM-15).
- 5. Part C Organization Determinations and Appeals, Grievances, Condition iv.** - ATRIO failed to respond to this quality of care grievance in writing, as required by CMS in 1 case. This condition was not validated as corrected because the same condition was identified in the only case available for review during the validation (GRV-6).
- 6. Compliance Program Effectiveness, Element VI. Effective System for Routine Monitoring, Auditing and Identification of Compliance Risks, Condition iii.** - ATRIO does not have a system for the auditing of compliance program effectiveness. This condition was not validated as corrected because Sponsor still did not have a system in place for the auditing of compliance program effectiveness.

The following new conditions identified during the validation:

- 1. Part D Coverage Determinations and Appeals - Effectuation Timeliness**-Sponsor did not effectuate its determination within 24 hours of receipt of the expedited coverage determination request for 2 samples tested during the validation (ET-11 and ET-12). The beneficiary may be confused regarding the status of the coverage determination, and/or appeal rights, and could potentially experience a lapse in coverage, a delay in access to care, and/or financial hardship. Sponsor must ensure that expedited coverage determinations are processed and effectuated timely.
- 2. Part D Coverage Determinations and Appeals – Appropriateness of Clinical Decision Making** - Sponsor did not notify the beneficiary or their prescriber, as appropriate, of its decision within 72 hours of receipt of a standard coverage determination request or, for an exceptions request, the physician's or other prescriber's supporting statement in 2 samples tested during the validation (CDM-9 and CDM-10).The beneficiary and their prescriber may be confused regarding the status of the coverage determination, and/or appeal rights, and could potentially experience a lapse in coverage, a delay in access to medication, and/or financial hardship. Sponsor must notify the beneficiary or their prescriber, as appropriate, of its decision within 72 hours of receipt of a standard coverage determination request or, for an exceptions request, the physician's or other prescriber's supporting statement.

The following observations:

- 1. Part D Coverage Determinations and Appeals – Appropriateness of Clinical Decision Making** - ATRIO's Medical Director agreed that, in one sampled case, the pharmacist denial should have been reviewed for medical appropriateness. Further, ATRIO's Medical Director and Sponsor's pharmacist indicated a policy requiring second review of denials will be considered.
- 2. Part D Coverage Determinations and Appeals – Appropriateness of Clinical Decision Making** - Sponsor did not demonstrate sufficient outreach to the prescriber or beneficiary to obtain additional information necessary to make an appropriate clinical decision. Sponsor's failure to conduct an adequate review of relevant clinical information, including making appropriate outreach efforts to obtain the information, could potentially delay access of care for the beneficiary. Sponsor must perform sufficient outreach to the prescriber or beneficiary to obtain additional information necessary to make an appropriate clinical decision.
- 3. Part D Coverage Determinations and Appeals – Appropriateness of Clinical Decision Making** - Sponsor did not appropriately auto-forward coverage determinations exceeding the CMS required timeframe to the IRE for review and disposition. The failure to make a decision or forward a case to the IRE in a timely manner increases the risk that

the beneficiary does not have access to needed medication. Sponsor must auto-forward a coverage determination not handled within the CMS required timeframe to the IRE for review and disposition upon discovery it has not met the required timeframes.

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. Janice Snyder at 206-615-3822 or via email at Janice.Snyder@cms.hhs.gov.

Sincerely,

/s/

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

cc:

Michelle Turano, CMS/CM/MOEG
Janice Snyder, Account Manager, CMS/ Region 10
Roya Rezai, Branch Manager, CMS/ Region 10
Brenda Suiter, Associate Regional Administrator, Region 10
Ms. Sara MacIntyre, Atrio Health Plans, sara.macintyre@atriohp.com
Mrs. Angela M. Lott, Atrio Health Plans, angela.lott@atriohp.com
Julie Uebersax, CMS/CM/MPPG
Robert Ahern, CMS/CM/MDBG
Tyler Whitaker, CMS/CM/MEAG
Kimberly August, CMS/CM/MCAG
Tanette Downs, CMS/CPI
Elizabeth Brady, CMS/CPI

