

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**

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**May 15, 2014**

E-MAIL: William\_Gracey@bcbst.com

Mr. Bill Gracey  
President and Chief Operating Officer  
Blue Cross Blue Shield of Tennessee, Inc.  
One Cameron Hill Circle  
Chattanooga, TN 37402

Re: 2012 Program Audit – Notice of Audit Closure for Medicare Advantage and/or Standalone Prescription Drug Plan Contracts: H5884 and H7917

Dear Mr. Gracey:

On February 7, 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 and Dismissals
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 Grievances, Condition iii.** – Sponsor did not provide accurate information to the beneficiary in the grievance resolution. This condition was not validated as corrected because the same condition was identified in 4 of 6 samples reviewed during the validation (GRV-3, GRV-4, GRV-5 and GRV-6).
2. **Part C Organization Determination and Appeals, Effectuation Timeliness, Condition i.** – Upon receipt of an organization determination request for payment, Sponsor did not pay or deny the claim within 30 calendar days of the date of the request for non-contracted providers and 60 calendar days for all other requests. Additionally, Sponsor did not pay interest on non-contracted provider claims that were older than 30 days. This condition was not validated as corrected because the same condition was identified in 5 of 5 samples reviewed during the validation (ET-1, ET-2, ET-3, ET-ALT1 and ET-ALT2).
3. **Part C Grievances and Dismissals, Grievances, Condition i.** – Sponsor did not fully resolve the beneficiary's grievance. This condition was not validated as corrected because the same condition was identified in 5 of 5 samples reviewed during the validation (GRV-1, GRV-2, GRV-3, GRV-4 and GRV-5).

**The following observations:**

1. **Part D Formulary and Benefit Administration, Formulary Administration** – Sponsor operationalized a CMS-approved quantity limit by using a quantity over time edit to look back over a period of time and determine the quantity already received. The use of quantity over time edits has the potential for access to medication issues. Sponsor should ensure that any quantity over time edits are monitored for potential medication access issues.
2. **Part C Organization Determination and Appeals, Effectuation Timeliness** – Sponsor misclassified cases in the Effectuation Timeliness universe by including denied cases in the paid claims universe. By not submitting accurate universes, CMS efforts in validating whether Sponsor's corrective actions implemented were effective in correcting issues identified in the program audit were hindered. CMS recommends that Sponsor ensure it provides accurate and complete information in response to CMS audit requests.
3. **Part C Organization Determination and Appeals, Effectuation Timeliness and Appropriateness of Clinical Decision Making** – Sponsor's initial denial letters for 2 reconsiderations sampled as well as 1 pre-service denial sampled did not contain enough information for the beneficiaries to understand the reason their requests were denied. Failure to include complete and accurate information as to the reason beneficiaries' requests for reconsiderations are denied in denial notifications can cause confusion among beneficiaries. CMS recommends that Sponsor monitor denial notices to ensure they contain language that a beneficiary is able to understand concerning the reason for denial.
4. **Part C Organization Determination and Appeals, Effectuation Timeliness** – Sponsor misclassified a grievance as a reconsideration. Based upon guidance in the Medicare Managed Care Manual, Chapter 13, Section 20.2, the beneficiary's expression of dissatisfaction about his co-payment subjects the complaint to the grievance process and not the appeals process. CMS recommends that Sponsor review its policies and procedures to ensure grievances are correctly classified.

5. **Part C Organization Determination and Appeals, Appropriateness of Clinical Decision Making** – Sponsor was observed to have dismissed a reconsideration without submitting a request for a dismissal to the IRE. No negative beneficiary impact was observed, however, Sponsor should review its policies and procedures to ensure requests for dismissals are appropriately forwarded to the IRE.
6. **Part C Organization Determination and Appeals, Appropriateness of Clinical Decision Making** – Sponsor was observed to have effectuated organization determinations approving requests for payment untimely in 2 sample cases. Sponsor should review its policies and procedures to ensure organization determinations are effectuated timely.
7. **Part C Organization Determination and Appeals, Appropriateness of Clinical Decision Making** – Sponsor did not conduct appropriate outreach to the provider to obtain the required documentation necessary to make an appropriate clinical decision on one payment request sampled. CMS recommends that Sponsor review its policies and procedures to ensure appropriate provider outreach is conducted to secure documentation necessary to make an informed decision about the clinical appropriateness of a payment request.
8. **Compliance Program Effectiveness, Effective Training and Education** – It was observed that one of Sponsor's delegated entity's policies and procedures required employees rehired during a calendar year to take compliance training again as if a new hire. CMS recommends that this policy and procedure be revised to defer compliance training for employees rehired in a calendar year to the following year's annual compliance training.
9. **Enrollment and Disenrollment, Denials** – Sponsor was observed to correct the deficiencies identified in its enrollment request denial processes. However, CMS recommends that Sponsor review its procedures and actions for removing enrollment applications from a hold status to a denied status as cases were observed with no denial reasons identified.

**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 AM 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 Mr. Darryl Brookins at 410-786-7542 or via email at [Darryl.Brookins@cms.hhs.gov](mailto:Darryl.Brookins@cms.hhs.gov).

**Mr. Bill Gracey**

**May 15, 2014**

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Sincerely,

/s/

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

cc:

Ms. Michelle Turano, CMS/CM/MOEG

Ms. Jennifer Bates, Audit Lead, CMS/CM/MOEG

Ms. Milagros Vargas-Bohaker, Account Manager, CMS/Region IV

Ms. Colleen Carpenter, Branch Manager, CMS/Region IV

Ms. Gloria Parker, Associate Regional Administrator, CMS/Region IV

Mr. John Giblin, Blue Cross Blue Shield of Tennessee, Inc., Chief Financial Officer,  
(via email: [John\\_Giblin@bcbst.com](mailto:John_Giblin@bcbst.com))

Mr. Michael Sneckenberger, Blue Cross Blue Shield of Tennessee, Inc., Compliance Officer  
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