

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

February 28, 2014

E-MAIL: mfn@centene.com

Mr. Michael F. Neidorff
Chairman and CEO
Centene Corporation
7700 Forsyth Boulevard
St. Louis, MO 63105
Telephone: 314-725-4477

Re: 2012 Program Audit – Notice of Audit Closure for Medicare Advantage and/or Standalone Prescription Drug Plan Contracts: H0908, H5294, H5590, H7173 and H8189

Dear Mr. Neidorff:

On February 22, 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/ 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 C Organization Determinations and Appeals- Grievances, Condition i.** - In 2 cases reviewed during the audit, Centene failed to fully investigate and address beneficiary complaints. This condition could not be validated as corrected because for 2 of 5 grievances sampled (GRV-1 & GRV-2), there was significant delay in contacting the appropriate parties and/or beneficiaries, beneficiaries received delayed care as a result, and Centene failed to fully investigate and address the member complaints.
- 2. Part C Organization Determinations and Appeals- Part C Access To Care, Misclassified Grievances, Condition ii.** - In 3 cases reviewed during the audit, the beneficiary grievances were not resolved. Centene failed to fully determine and address beneficiary medical condition and ensure needs were met. This condition could not be validated as corrected because for 2 of 5 grievances sampled (GRV-1 & GRV-2), there was significant delay in contacting the appropriate parties and/or beneficiaries, beneficiaries received delayed care as a result, and Centene failed to fully investigate and address the member complaints.
- 3. Part D Formulary & Benefit Administration, Additional Findings, Condition iii.** - In one case reviewed during the audit, Centene implemented unapproved quantity limits. This condition could not be validated as corrected because five cases (FA-11, FA-12, FA-13, FA-14, and FA-15), failed for this issue during the ICAR validation review.
- 4. Part D Formulary & Benefit Administration, Additional Findings, Condition v.** - In 2 cases reviewed during the audit, Centene improperly rejected formulary drugs, (i.e., inhalation, injectable preparations, etc.), when dispensed in the smallest commercially available package size and accurately calculated for a greater than 30 day supply. One sample had a related paid claim after the day supply was changed to 30 days and resubmitted. The other sample did not have a related paid claim. This condition could not be validated as corrected because five cases (FA-16, FA-17, FA-18, FA-19, and FA-20) failed for this issue during the ICAR validation review.

The following new condition identified during the validation:

- 1. Part D Coverage Determinations and Appeals, Appropriateness of Clinical Decision-Making & Compliance with Processing Requirements** - Centene misclassified coverage determination or redetermination requests as customer service inquiries (CDM-01 and CDM-03). Sponsor lacks adequate controls to ensure that requests for determinations are appropriately classified. The beneficiary may be confused regarding the status of the coverage determination as the denial notification received was for an inquiry. Centene must ensure that coverage determination and redetermination requests are treated as such, rather than a grievance or customer service inquiry.

The following observations:

- 1. Part D Coverage Determinations and Appeals, Effectuation Timeliness**-Centene inappropriately allowed a one-time override to allow the beneficiary access to their medication.

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Centene lacks adequate controls to ensure that prescription coverage is applied consistently and appropriately for all beneficiaries. Centene should enhance standard procedures to ensure that appropriate procedures are equally applied to all determination requests, and to ensure that overrides are prohibited unless the circumstance is allowed otherwise.

2. **Part D Coverage Determinations and Appeals - Effectuation Timeliness, Condition vi-** Centene utilized inconsistent practices when notifying beneficiaries of B vs. D determinations including no notification, coverage determination notices, and notices of inquiry. The Sponsor does not have adequate procedures in place to appropriately and consistently notify beneficiaries of the outcome of B vs. D determinations. Centene should implement standardized policies and procedures related to B vs. D determinations to ensure beneficiaries are appropriately and timely notified of the decision.
3. **Part C Organization Determinations and Appeals- Grievances, Condition ii-** Centene failed to resolve beneficiary grievances related to quality of care issues from providers affiliated with a dental delegated entity. This condition could not be validated during the ICAR validation process because there were insufficient samples present. There were also no grievances in the CAR validation universe specific to the dental delegated entity, so the condition could not be validated.

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 Mr. Darryl Brookins at 410-786-7542 or via email at Darryl.Brookins@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
Erica M. Colbert, Audit Lead, CMS/CM/MOEG

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Janice Snyder, Account Manager, CMS/ CMHPO/Region X

Roya Rezai, Branch Manager, CMS/CMHPO/Region X

Brenda Suiter, Associate Regional Administrator, CMS/CMHPO/Region X

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

Michelle Jones, Centene Corporation, Director of Compliance (via email: mijones@centene.com)