

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 2, 2014**

**E-MAIL: ([TByrd@healthfirst.org](mailto:TByrd@healthfirst.org))**

Mr. Terrence Byrd  
President  
Healthfirst Health Plan of New Jersey, Inc.  
100 Church Street, 18th Floor  
New York, New York 10007

Re: 2012 Program Audit – Notice of Audit Closure for Medicare Advantage and/or Standalone Prescription Drug Plan Contracts: H7015

Dear Mr. Byrd:

On December 19, 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. 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, Grievances, Condition i.** - Healthfirst failed to appropriately address all issues raised in the complaint. This condition could not be validated as corrected because the same condition was identified 1 out of 2 samples reviewed during the validation (GRV-2).
- 2. Part C Organization Determinations and Appeals, Appropriateness of Clinical Decision Making, Condition i.** – Healthfirst unilaterally denied an organization determination without first doing outreach to their network provider to obtain the necessary clinical information. This condition could not be validated as corrected because the same condition was identified in 3 out of 5 samples reviewed during the validation (CDM-3, CDM-4, and CDM-5).
- 3. Part C Organization Determinations and Appeals, Appropriateness of Clinical Decision Making, Condition ii.** – Healthfirst unilaterally denied an organization determination without first consulting the provider and due to lack of documentation. This condition could not be validated as corrected because the same condition was identified in 3 out of 5 cases reviewed during the validation (CDM-3, CDM-4, and CDM-5).
- 4. Part C Organization Determinations and Appeals, Appropriateness of Clinical Decision Making, Condition iii.** – Healthfirst unilaterally denied an organization determination without first consulting the in-network provider due to lack of documentation. This condition could not be validated as corrected because the same condition was identified in 3 out of 5 cases reviewed during the validation (CDM-3, CDM-4, and CDM-5).
- 5. Part C Organization Determinations and Appeals, Appropriateness of Clinical Decision Making, Condition iv.** - Healthfirst inappropriately sent the beneficiary a notice of denial with appeal rights inferring beneficiary liability when there was none. This condition could not be validated as corrected because the same condition was identified in all 5 cases reviewed during the validation (CDM-6, CDM-7, CDM-8, CDM-9, and CDM-10).

**The following observations:**

- 1. Part C Organization Determinations and Appeals, Appropriateness of Clinical Decision Making** - Healthfirst failed to properly oversee a delegated entity which processed post-denial information as a reopening of an organization determination request rather than as an appeal. Healthfirst's delegated entity's practice is to process the receipt of post-denial information as a reopening rather than an appeal, thereby, denying beneficiaries' appeal rights. This practice is inconsistent with CMS guidelines.
- 2. Part C Organization Determinations and Appeals, Appropriateness of Clinical Decision Making** – Healthfirst inappropriately granted itself an extension to the standard processing timeframe the day after the organization determination request was received. Healthfirst should review its processes and strengthen its oversight of its delegated entities to ensure the use of extensions is in compliance with CMS requirements.
- 3. Part C Organization Determinations and Appeals, Appropriateness of Clinical Decision Making** – A denial letter provided to the beneficiary did not include an adequate rationale or contained incorrect information specific to the denial. Healthfirst should ensure that denial letters are complete and accurate, including an adequate rationale specific to the denial.

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- 4. Part C Organization Determinations and Appeals, Appropriateness of Clinical Decision Making** – Healthfirst did not notify the beneficiary or the provider, as appropriate, of its decision within 14 calendar days of receipt of a standard organization determination request. Healthfirst should ensure that timely notifications of organization determinations are provided to beneficiaries.
- 5. Part C Organization Determinations and Appeals, Grievances** - Healthfirst failed to notify the beneficiary of the resolution of a grievance within CMS required timeframes or as expeditiously as the beneficiary's case required. Healthfirst should ensure that beneficiaries are notified of grievance resolutions timely.

**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. Harold Goodwin at 212-616-2317 or via email at [Harold.Goodwin@cms.hhs.gov](mailto:Harold.Goodwin@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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