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:Alex.Fuster@healthsun.com

Alexander Fuster
Chief Executive Officer
HealthSun Health Plan
3250 Mary Street
Suite 300
Coconut Grove, Florida 33133
1-305-234-9292

Re: 2012 Program Audit – Notice of Audit Closure for Medicare Advantage and/or Standalone Prescription Drug Plan Contracts: H5431

Dear Mr. Fuster:

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. 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 C Organization Determinations and Appeals, Effectuation Timeliness, Condition ii.** - HealthSun failed to provide timely notification of the payment decision to the enrollee and/or provider in 9 cases reviewed during the audit. The root cause for this condition not passing the validation is HealthSun does not have an adequate process in place to ensure beneficiaries receive timely notifications of payment decisions. This condition was observed in all 10 cases reviewed during the validation (CDM-6, CDM-7, CDM-8, CDM-9, CDM-10, CDM-11, CDM-12, CDM-13, CDM-14 and CDM-15).

2. **Part C Organization Determinations and Appeals, Effectuation Timeliness, Condition iii.** - HealthSun failed to ensure that payment requests were addressed within the CMS-required 60-day time frame in 6 cases reviewed during the audit. The root cause for this condition not passing the validation is HealthSun does not have an adequate process in place to ensure organization determinations for payment requests are processed timely. This condition was noted in all 5 cases reviewed during the validation (CDM-6, CDM-7, CDM-8, CDM-9 and CDM-10).

3. **Part C Organization Determinations and Appeals, Effectuation Timeliness, Condition iv.** - HealthSun failed to ensure that payment requests were addressed within the CMS-required 30-day time frame in 3 cases reviewed during the audit. The root cause for this condition not passing the validation is HealthSun does not have an adequate process in place to ensure organization determinations for payment requests are processed timely. This condition was observed in all 5 cases reviewed during the validation (CDM-11, CDM-12, CDM-13, CDM-14 and CDM-15).

4. **Part C Organization Determinations and Appeals, Appropriateness of Clinical Decision-Making, Condition v.** - HealthSun did not pay the non-contracted provider within 30 calendar days of the request in 2 cases reviewed during the audit. The root cause for this condition not passing the validation is HealthSun does not have an adequate process in place to ensure adverse organization determinations are processed timely. This condition was observed in all 5 cases reviewed during the validation (CDM-11, CDM-12, CDM-13, CDM-14 and CDM-15).

5. **Part C Grievances, Dismissals, Condition i.** - HealthSun did not forward the cases timely to the IRE in 9 cases reviewed during the audit. The root cause for this condition not passing the validation is HealthSun does not have an adequate process in place to ensure dismissed cases are processed timely and forwarded to the IRE. This condition was noted in all 5 cases reviewed during the validation (DIS-1, DIS-2, DIS-3, DIS-4 and DIS-5).

6. **Compliance Program Effectiveness, Element III, Condition i.** - HealthSun did not provide evidence that compliance and FWA training was being provided to its governing body in accordance with CMS requirements. There was no evidence provided that compliance and FWA training was implemented for the board. This condition was noted in 1 case (Employee Record Sample #5) reviewed during the validation.

7. **Compliance Program Effectiveness, Element IX, Condition iii.** - HealthSun does not have a system for routine monitoring or auditing of their FDRs to ensure compliance with CMS regulations. HealthSun was unable to provide evidence of sufficient monitoring for all 5 first tier entity samples reviewed during the audit. HealthSun indicated they have insufficient resources dedicated to auditing their FDRs. This condition was noted in 3 cases reviewed during the validation (First Tier Samples #2, #3 and #5).

The following condition has not yet been validated:

1. **Compliance Program Effectiveness, Element III, Condition ii.** - HealthSun did not provide evidence that compliance training was consistently being provided upon hire and on annual basis to its senior management and employees. One case out of 5 reviewed during the audit did not have evidence of compliance training upon hire and 4 out of 5 cases reviewed during the audit did not have evidence of annual compliance training. This condition could not be validated because the annual training does not occur until subsequent to the date of validation.

The following observations:

1. **Part D Coverage Determinations and Appeals, Effectuation Timeliness** - Claims for Procrit were denied on May 29, 2013 and May 31, 2013 from an out of network pharmacy. A coverage determination request was not received until June 10, 2013. In light of the multiple rejections and the nature of the drug, HealthSun should have reached out to the pharmacy.

2. **Part D Coverage Determinations and Appeals, Appropriateness of Clinical Decision-Making** - A coverage determination request was denied because the drug was not covered by Part D. The denial letter was timely sent to the beneficiary; however, the letter would be more helpful to the beneficiary and prescriber if it contained alternatives to the non-covered drug.

3. **Part D Coverage Determinations and Appeals, Appropriateness of Clinical Decision-Making** - Upon submission of a coverage determination request, HealthSun requested additional information from the provider to support the non-formulary exception request. However, they made only one attempt to obtain the information before denying the request for non-submission of the information.

4. **Part C Organization Determinations and Appeals, Effectuation Timeliness** - HealthSun inappropriately denied payment for emergency medical services. HealthSun denied a claim for motor vehicle accident treatment because automobile insurance would have been the primary payer; however no documentation supported that automobile insurance existed as a primary payer. HealthSun's denial of payment for a service could potentially cause a delay and/or denial of access to care and/or financial hardship for the beneficiary. HealthSun must ensure that payment for emergency medical services is not denied.

5. **Part C Organization Determinations and Appeals, Effectuation Timeliness** - HealthSun denied payment for a service that was considered Sponsor directed care. HealthSun denied this claim in error. The referring physician was a contracted provider on the date of service.

HealthSun's denial of payment for a service could potentially cause a delay in access to care and/or financial hardship for the beneficiary. HealthSun must ensure that payment is not denied for a service that is considered Sponsor directed care.

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
Jennifer Bates, Audit Lead, CMS/CM/MOEG
Shannon Comage, Account Manager, CMS/CMHPO/Region IV
Michael Taylor, Branch Manager, CMS/CMHPO/Region IV
Gloria Parker, Associate Regional Administrator, CMS/CMHPO/Region IV
Gale Lam, HealthSun Health Plans, Inc., Chief Financial Officer (Via email: cms_administrator@healthsun.com)
Marianela de la Llama, HealthSun Plans, Inc., Compliance Office, (via email: cms_compliance@healthsun.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