

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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**July 25, 2014**

E-MAIL: [Robert.Gootee@ModaHealth.com](mailto:Robert.Gootee@ModaHealth.com)

Robert Gootee  
CEO  
Health Services Group, Inc.  
601 S.W. Second Avenue, Suite 900  
Portland, OR 97204

Re: 2013 CMS Program Audit – Notice of Audit Closure for Medicare Advantage and Prescription Drug Plans Numbers: H3813, S5975

Dear Mr. Gootee:

On January 22, 2014, 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 and Grievances
3. Part C Organization Determinations and Appeals and Grievances
4. Parts C & D Compliance Program Effectiveness
5. Part C and Part D Outbound Enrollment Verification Calls (OEV)

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. However, the following observations were noted:**

- 1. Part D Coverage Determinations, Appeals, and Grievances, Effectuation Timeliness and Appropriateness of Clinical Decision Making:** Sponsor did not demonstrate tracking and trending of the audit results. Although specific issues are documented and addressed, trending the

findings will lead to the identification of additional issues related to individuals or processes. Sponsor should develop a method for tracking and trending the results of the audits.

2. **Part D Coverage Determinations, Appeals, and Grievances, Appropriateness of Clinical Decision Making:** Although Sponsor has provided a template and appropriate attachments for denial letters that includes the request for redetermination form with the appeal rights; the template that was superseded is still available on the Intranet. This leads to the risk that a coordinator could select and send the incorrect version. Sponsor should ensure only the current document versions are accessible for use.
3. **Part C Organizations Determinations, Appeals, Grievances, and Dismissals, Effectuation Timelines:** Sponsor's policy (Claims Paid and Denial Dates, MED 1756) appears to be inconsistent with the CMS requirement to send a beneficiary denial notice when services or payment are denied. The policy suggests that a denial notice is only sent when a claim results in beneficiary liability rather than whenever there is a denial. Sponsor's policy cites, in pertinent part, "...When a claim is denied and results in member liability, a Notice of Denial is mailed to the member..." Per the Medicare Managed Care Manual (Chapter 13, Section 40.2.1) and Code of Federal Regulations [42CFR422.568(d)], the MA organization must give the enrollee a written notice if...decides to deny service or payment in whole or in part, or reduce or prematurely discontinue the level of care for a previously authorized ongoing course of treatment.
4. **Part C Organization Determinations, Appeals, Grievances, and Dismissals, Appropriateness of Clinical Decision Making:** Sponsor's Medical Quality Improvement Committee (MQIC) meeting minutes should reflect findings, conclusions, recommendations and actions relative to departmental audit results presented to it. The minutes reviewed during the validation audit merely cited presentation of the results.

**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](mailto:Darryl.Brookins@cms.hhs.gov).

Sincerely,

**Robert Gootee**

**July 25, 2014**

Page 3 of 3

/s/

Tawanda Holmes

Director, Division of Audit Operations

Medicare Parts C and D Oversight and Enforcement Group