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

May 15, 2014

E-MAIL: rmarino@horizonblue.com

Robert A. Marino
President and Chief Executive Officer
Horizon Healthcare Services, Inc.
Three Penn Plaza East, PP-16A
Newark, NJ 07105

Re: 2012 Program Audit – Notice of Audit Closure for Medicare Advantage and/or Standalone Prescription Drug Plan Contracts: H3154 and S5993

Dear Mr. Marino:

On February 15, 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 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 C Organization Determinations and Appeals, Appropriateness of Clinical Decision Making, Condition ii.** - Horizon BCBSNJ provided a Notice of Denial of Medical Coverage that failed to include appropriate criteria language and was not written in a manner that the beneficiary could understand. This condition was not validated as corrected because the same condition was identified in 8 of 27 samples reviewed during the validation (CDM-13, CDM-14, CDM-15, CDM-19, CDM-20, CDM-22, CDM-23, and CDM-24).
2. **Part C Organization Determinations and Appeals, Appropriateness of Clinical Decision Making, Condition vi.** – Horizon BCBSNJ failed to process the request from a contracted provider or a provider referred by a contracted Plan provider as Plan directed care and, therefore, improperly imposed beneficiary liability. This condition was not validated as corrected because the same condition was identified in 3 of 13 samples reviewed during the validation (CDM-16, CDM-17, and CDM-19).
3. **Part C Organization Determinations and Appeals, Appropriateness of Clinical Decision Making, Condition viii.** – Horizon BCBSNJ did not exercise reasonable and diligent efforts to obtain the information it needed from the provider in order to make an appropriate clinical decision. This condition was not validated as corrected because the same condition was identified in 8 of 27 samples reviewed during the validation (CDM-4, CDM-7, CDM-10, CDM-12, CDM-16, CDM-17, CDM-19, and CDM-30).
4. **Part C Organization Determinations and Appeals, Appropriateness of Clinical Decision Making, Condition x.** – Horizon BCBSNJ failed to consider all clinical information and made a decision to deny the request for payment inconsistent with the beneficiary's medical condition. This condition was not validated as corrected because the same condition was identified in 8 of 27 samples reviewed during the validation (CDM-4, CDM-7, CDM-10, CDM-12, CDM-16, CDM-17, CDM-19, and CDM-30).
5. **Part C Organization Determinations and Appeals, Appropriateness of Clinical Decision Making, Condition xi.** – Horizon BCBSNJ failed to provide or pay for a medically necessary Medicare-covered service. This condition was not validated as corrected because the same condition was identified in 8 of 27 samples reviewed during the validation (CDM-4, CDM-7, CDM-10, CDM-12, CDM-16, CDM-17, CDM-19, and CDM-30).

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 Ms. Kelli Singleton at 212-616-2219 or via email at Kelli.Singleton@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
Kelli Singleton, Account Manager, CMS/Region II
Reginald Slaten, Associate Regional Administrator, CMS/Region II
Rachel Walker, Branch Manager, CMS/Region II
Mr. David Huber, Horizon Healthcare of New Jersey, david_huber@horizonblue.com
Mr. Timothy Susanin, Horizon Healthcare of New Jersey, timothy_susanin@horizonblue.com
Julie Uebersax, CMS/CM/MPPG
Sonia Eaddy, CMS/CM/MDBG
Tyler Whitaker, CMS/CM/MEAG
Kimberly August, CMS/CM/MCAG
Tanette Downs, CMS/CPI
Elizabeth Brady, CMS/CPI