

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

April 23, 2014

E-MAIL: (muchrin@iasishealthcare.com)

Mr. Mike Uchrin
Chief Executive Officer
IASIS Healthcare
410 N. 44th Street
Suite 510
Phoenix, AZ 85008

Re: 2012 Program Audit – Notice of Audit Closure for Medicare Advantage and/or Standalone Prescription Drug Plan Contracts: H5587

Dear Mr. Uchrin:

On February 8, 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 D Formulary and Benefit Administration, Formulary Administration, Condition iii** - IASIS Healthcare failed to administer its CMS approved formulary by enacting unapproved quantity limits. This condition was not validated as corrected because the same condition was identified in 5 of 5 samples reviewed during the validation (FA-6, FA-7, FA-8, FA-9, and FA-10).
2. **Part D Coverage Determinations and Appeals, Effectuation Timeliness, Condition vi** - IASIS Healthcare did not make expedited coverage determination decisions within 24 hours of receipt of the expedited coverage determination request. This condition was not validated as corrected because the same condition was identified in 8 of 8 samples reviewed during the validation (ET-01, ET-02, ET-06, ET-07, ET-09, ET-12, ET-13 and ET-14).
3. **Part D Coverage Determinations and Appeals, Effectuation Timeliness, Condition xi** - The notification to the beneficiary did not explain the conditions of the approval in a readable and understandable form. This condition was not validated as corrected because the same condition was identified in 3 of 17 samples reviewed during the validation (ET-08, ET-13, and ET-15).
4. **Part D Coverage Determinations and Appeals, Appropriateness of Clinical Decision-Making and Compliance with Processing Requirements, Condition iii** - IASIS Healthcare did not auto-forward expedited coverage determinations exceeding the required 24 hours timeframe to the IRE for review and disposition. This condition was not validated as corrected because the same condition was identified in 4 of 5 samples reviewed during the validation (CDM-03, CDM-08, CDM-09 and CDM-10).
5. **Part D Coverage Determinations and Appeals, Appropriateness of Clinical Decision-Making and Compliance with Processing Requirements, Condition v** - IASIS Healthcare did not make expedited coverage determination decisions within the required timeframe of 24 hours after receiving the request. This condition was not validated as corrected because the same condition was identified in 2 of 5 samples reviewed during the validation (CDM-03 and CDM-08).
6. **Part D Coverage Determinations and Appeals, Appropriateness of Clinical Decision-Making and Compliance with Processing Requirements, Condition vii** - IASIS Healthcare did not notify the beneficiary of its determination within 24 hours of receipt of the expedited coverage determination request. This condition was not validated as corrected because the same condition was identified in 3 of 5 samples reviewed during the validation (CDM-03, CDM-08, and CDM-10).
7. **Part D Coverage Determinations and Appeals, Appropriateness of Clinical Decision-Making and Compliance with Processing Requirements, Condition ix** - IASIS Healthcare made a negative coverage determination without conducting the required outreach to the prescriber to obtain the prescriber's supporting statement necessary to make determination. This condition was not validated as corrected because the same condition was identified in 2 of 5 samples reviewed during the validation (CDM-02 and CDM-05).
8. **Part C Organization Determination and Appeals, Effectuation Timeliness, Condition iii** - IASIS Healthcare failed to ensure that the beneficiary was notified of the expedited pre-service organization determination within the 72-hour timeframe. This condition was not validated as corrected because the same condition was identified in 5 of 5 samples reviewed during the validation (ET-01, ET-02, ET-03, ET-04, and ET-05).

- 9. Part C Organization Determination and Appeals, Appropriateness of Clinical Decision-Making, Condition ii** – IASIS Healthcare did not make sufficient effort to obtain necessary clinical information from a provider. This condition was not validated as corrected because the same condition was identified in 3 of 5 samples reviewed during the validation (CDM-01, CDM-02, and CDM-04).
- 10. Part C Organization Determination and Appeals, Appropriateness of Clinical Decision-Making, Condition iii** - IASIS Healthcare did not provide a Notice of Denial of Medical Coverage that included appropriate criteria language and was written in a manner that the beneficiary could understand. This condition was not validated as corrected because the same condition was identified in 5 of 5 samples reviewed during the validation (CDM-01, CDM-02, CDM-03, CDM-04, and CDM-05).

Applicable transition findings were covered by Medicare Drug Benefit and C & D Data Group's (MDBG) Transition Monitoring Program Analysis (TMPA). The results of that analysis and any resulting compliance action(s) will be followed up with by MDBG and your Account Manager.

The following new conditions identified during the validation:

- 1. Part C Organization Determination and Appeals, Appropriateness of Clinical Decision-Making** - IASIS Healthcare failed to ensure that organization determination requests for payment decisions were processed and all parties were notified of the decisions timely for supplemental dental services. IASIS Healthcare's standard policies and procedures do not require notifications to beneficiaries when requests for payment for supplemental dental services are denied. Failure to provide notifications of denials of payment requests to beneficiaries could expose beneficiaries to potential financial liability (CDM-15).
- 2. Part C Organization Determination and Appeals, Appropriateness of Clinical Decision-Making** - IASIS Healthcare did not notify beneficiaries after affirming its decisions to deny payment reconsiderations. IASIS Healthcare did not provide notifications of the denials to the beneficiaries because it believed that there was no beneficiary liability. The failure to provide timely notification of payment decisions may result in beneficiary confusion regarding the status of the redetermination, and/or appeal rights, and could potentially cause financial hardship (CDM-14, CDM-15, CDM-16, and CDM-17).
- 3. Part C Organization Determination and Appeals, Appropriateness of Clinical Decision-Making** – IASIS Healthcare failed to notify the beneficiary that his/her reconsideration request was auto forwarded to the IRE. Notification of the forwarding of reconsideration requests to the IRE is made via use of the notification of the affirmation of the decision to deny payment reconsiderations. Since IASIS Healthcare did not provide such notification as it believed there was no beneficiary liability, the notification of the forwarding of the reconsideration request to the IRE was also not provided. The failure to provide notification to beneficiaries of the auto forwarding of reconsideration requests to the IRE could result in beneficiary confusion as to the status of his/her reconsideration request as well as potential that beneficiaries could be balanced billed (CDM-14, CDM-15, CDM-16, and CDM-17).

The following observations:

- 1. Part D Formulary and Benefit Administration, Formulary Administration – IASIS Healthcare** rejected formulary medications as non-formulary as the result of a formulary update that contained incorrect information. This issue was self-identified and reported to IASIS Healthcare's CMS Account Manager, including beneficiary impact analyses and corrective actions.
- 2. Part C Organization Determination and Appeals, Effectuation Timeliness –** It was noted in 1 case sampled that IASIS Healthcare's request for additional information from the provider was not specific as to what information was needed. It was also noted in this case that IASIS Healthcare issued a denial for the requested procedure after approving a request for the service. IASIS Healthcare stated that it did not want the beneficiary to have 2 authorizations for the same service but issuing a denial after issuing an approval for the same service requested is inappropriate and can be confusing to a beneficiary. IASIS Healthcare should strengthen its internal controls to ensure requests of providers for additional information are specific as to what is required and to ensure a decision to deny a requested service is not issued when a decision to approve the service has been previously made and communicated to a beneficiary.
- 3. Part C Organization Determination and Appeals, Appropriateness of Clinical Decision-Making –** It was noted in 1 case sampled that IASIS Healthcare did not ensure that the initiation of the organization determination, reconsideration, or grievance was by an authorized representative of the beneficiary. Failure to verify the legitimacy of an organization determination, reconsideration, or grievance request could result in the inappropriate release of federally protected personal health information, a HIPAA violation.
- 4. Part C Grievances, Grievances –** It was noted in 1 case sampled that IASIS Healthcare failed to correctly determine whether the issues in the beneficiary's complaint met the definition of a grievance, an appeal, or both and, therefore, did not resolve the complaints or disputes through the appropriate procedure. Failure to properly classify a complaint as a grievance and/or an appeal can potentially lead to a delay and/or denial of access to care, denies access to appeal rights, and/or financial hardship for the beneficiary.
- 5. Part C Grievances, Grievances –** It was noted in 1 case sampled that IASIS Healthcare did not take appropriate action, including a full investigation, and/or appropriately addressing all issues raised in the grievance. The lack of appropriate action and investigation of beneficiary grievances creates potential for issues brought forth by beneficiaries to continue occurring, as well as the potential for a delay or denial in access to care and/or financial hardship.
- 6. Part C Grievances, Dismissals –** It was noted that IASIS Healthcare did not include due dates on the initial request for a Waiver of Liability (WoL) nor on follow up requests. Sponsor should include a due date on the initial request for a WoL as well as follow up requests to ensure providers are fully aware of when the requested WoL is due as well as the consequences for failing to comply with the requests.
- 7. Compliance Program Effectiveness, Element IX, FDR Oversight –** It was noted in 2 of 5 first tier entities sampled that there was lack of evidence of FWA training requirements being met. Both first tier entities were limited to credentialing, and IASIS Healthcare acknowledged that it does not provide FWA training to its delegated credentialing first tier entities and there is no system in place to do so currently. IASIS Healthcare should implement procedures to ensure all first tier entities are in compliance with CMS FWA training requirements.

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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. Susan Castleberry at 415-744-4688 or via email at Susan.Castleberry@cms.hhs.gov.

Sincerely,

/s/

Tawanda Holmes

Director, Division of Audit Operations

Medicare Parts C and D Oversight and Enforcement Group

cc:

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