

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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April 7, 2014

E-MAIL: [Orlando.gonzalez@mmmhc.com](mailto:Orlando.gonzalez@mmmhc.com)

Mr. Orlando Gonzalez  
President and CEO  
InnovaCare, Inc.  
350 Avenida Chardon  
Torre Chardon, Suite 500  
San Juan, Puerto Rico 00918

Re: 2012 Program Audit – Notice of Audit Closure for Medicare Advantage and/or Standalone Prescription Drug Plan Contracts: H4003, H4004 and S0043

Dear Mr. Gonzalez:

On November 29, 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/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, Effectuation Timeliness, Condition iii. – In 4 cases reviewed during the audit, Aveta issued a decision to the beneficiary when they auto-forwarded the case to the IRE. These cases include 2 standard coverage determinations, 1 expedited coverage determination, and 1 expedited redetermination. This condition could not be validated as corrected because the same condition was identified in 4 out of 5 samples reviewed during the validation (ET-6, ET-8, ET-9 and ET-10).
2. Part D Coverage Determinations and Appeals, Appropriateness of Clinical Decision Making & Compliance with Processing Requirements, Condition iii. - In 4 cases reviewed during the audit, the denial letter issued to the beneficiary did not include adequate information specific to the case and did not clearly document next steps to obtain coverage or formulary alternatives. These cases include 3 coverage determinations and 1 redetermination. This condition could not be validated as corrected because the same condition was identified in 4 out of 5 samples reviewed during the validation (CDM-1, CDM-2, CDM-3, and CDM-5).

The following observations:

1. Part D Coverage Determinations and Appeals, Appropriateness of Clinical Decision Making & Compliance with Processing Requirements – Aveta denied coverage determination requests for not meeting criteria after unsuccessful attempts to obtain a supporting statement from a contracted provider. Not obtaining relevant information from a beneficiary's provider increases the risk that requests will be inappropriately denied or delayed. CMS recommends that Aveta's Medical Director enhance oversight of this area to ensure providers under contract with the Plan are responding to support for coverage determination requests timely (CDM-1, CDM-2 and CDM-3).
2. Part C Organization Determinations and Appeals, Effectuation Timeliness – Aveta failed to provide a denial notice, including appeal rights, after denying a request for payment from a non-contracted provider. Not providing a denial notice increases the risk of financial harm to the beneficiary. CMS recommends that Aveta send denial notices for all such requests in the future.

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.

Mr. Orlando Gonzalez

April 7, 2014

Page 3 of 3

If you have any questions concerning this notice, please contact Mr. Edgardo Reyes at 212-616-2315 or by email at [Edgardo.Reyes@cms.hhs.gov](mailto:Edgardo.Reyes@cms.hhs.gov).

Sincerely,

/s/

Tawanda Holmes

Director, Division of Audit Operations

Medicare Part C and D Oversight and Enforcement Group