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

July 9, 2015

Ms. Angela Huschka
Chief Financial Officer
New West Health Services
130 Neill Avenue
Helena, MT 59601

Re: Notice of Imposition of Civil Money Penalty for Medicare Advantage-Prescription Drug
Contract Number: H2701

Dear Ms. Huschka,

Pursuant to 42 C.F.R. § 422.752(c)(1), § 422.760(b), § 423.752(c)(1), and § 423.760(b), the Centers for Medicare & Medicaid Services (CMS) is providing notice to New West Health Services (NWHS) that CMS has made a determination to impose a civil money penalty (CMP) in the total amount of **$204,200** for Medicare Advantage-Prescription Drug (MA-PD) Contract Number: H2701.

CMS has determined that NWHS failed to provide its enrollees with Medicare benefits in accordance with CMS requirements. An MA-PD oganization's central mission is to provide Medicare enrollees with medical services and prescription drug benefits within a framework of Medicare requirements that provide enrollees with a number of protections.

Summary of Noncompliance

CMS conducted a validation audit of NWHS's Medicare operations from April 22, 2015 through April 23, 2015. On May 12, 2015, CMS auditors reported to NWHS that it failed to demonstrate correction of certain Immediate Corrective Action Required (ICAR) audit deficiencies that were found in its original audit. These deficiencies violated Medicare requirements and were cited in the Notice of Imposition of Civil Money Penalty issued by CMS to NWHS on January 29, 2015 for failing to comply with Medicare requirements related to Part C and Part D organization/coverage determinations, appeals, and grievances in violation of 42 C.F.R. Part 422, Subpart M and 42 C.F.R. Part 423, Subpart M. The deficiencies cited in this notice remained uncorrected at the time of the validation audit and adversely affected (or had the substantial likelihood of adversely affecting) enrollees by causing inappropriate delays or denials in receiving covered benefits or increased out-of-pocket costs.

Part C and Part D Organization/Coverage Determination, Appeal, and Grievance Relevant Requirements
(42 C.F.R. Part 422, Subpart M; 42 C.F.R. Part 423, Subpart M; IOM Pub. 100-18 Medicare Prescription Drug Benefit Manual, Chapter 18; IOM Pub. 100-16 Medicare Managed Care Manual, Chapter 13)

Medicare enrollees have the right to contact their plan sponsor to express general dissatisfaction with the operations, activities, or behavior of the plan sponsor or to make a specific complaint about the denial of coverage for drugs or services to which the enrollee believes he or she is entitled. Sponsors are required to classify general complaints about services, benefits, or the sponsor's operations or activities as grievances. Sponsors are required to classify complaints about coverage for drugs or services as organization determinations (Part C – medical services) or coverage determinations (Part D – drug benefits). It is critical for a sponsor to properly classify each complaint as a grievance or an organization/coverage determination or both. Improper classification of an organization or coverage determination denies an enrollee the applicable due process and appeal rights and may delay an enrollee's access to medically necessary or life-sustaining services or drugs.

The enrollee, the enrollee's representative, or the enrollee's treating physician or prescriber may make a request for an organization determination or coverage determination. The first level of review is the organization determination or coverage determination, which is conducted by the plan sponsor, and the point at which beneficiaries or their physicians submit justification for the benefit.

If the organization or coverage determination is adverse (not in favor of the beneficiary), the beneficiary has the right to file an appeal. The first level of the appeal – called a reconsideration (Part C) or redetermination (Part D) – is handled by the plan sponsor and must be conducted by a physician who was not involved in the organization determination or coverage determination decision. The second level of appeal is made to an independent review entity (IRE) contracted by CMS.

There are different decision making timeframes for the review of organization determinations, coverage determinations, and appeals. CMS has a beneficiary protection process in place that requires plans to forward coverage determinations and appeals to the IRE when the plan has missed the applicable adjudication timeframe.

Violations Related to Part C and Part D Organization/Coverage Determinations, Appeals and Grievances

CMS identified violations of Part C and Part D organization/coverage determination, appeal, and grievance requirements that had the substantial likelihood of adversely affecting NWHS's enrollees. NWHS's violations include:

1. Failure to auto-forward coverage redeterminations to the Independent Review Entity (IRE) for review and disposition. As a result, enrollees did not receive an independent review of their reimbursement requests, which were denied by NWHS. This is in

violation of 42 C.F.R. § 423.590(c), § 423.590(e); and IOM Pub. 100-18 Medicare Prescription Drug Benefit Manual, Chapter 18, Sections 70.7.1, and 70.8.2.

2. Failure to make payment decisions within 60 days after the receipt of organization determination requests for non-contracted providers. As a result, non-contracted providers were not paid on-time and may have sought payment from Medicare enrollees. This is in violation of 42 C.F.R. § 422.520(a); and IOM Pub. 100-16 Medicare Managed Care Manual, Chapter 13, Section 40.1, Paragraph 3.

3. Failure to notify beneficiaries, or their providers as appropriate, of its decision within 72 hours of receipt of pre-service expedited organization determination requests. As a result, enrollees may have experienced inappropriate delays in receiving medical services. This is in violation of 42 C.F.R. § 422.572(a); and IOM Pub. 100-16 Medicare Managed Care Manual, Chapter 13, 50.4, Paragraph 1, Bullet 1.

Basis for Civil Money Penalty

Pursuant to 42 C.F.R. § 422.752(c)(1), § 422.760(b), § 423.752(c)(1), and § 423.760(b), CMS has determined that NWHS's violations of Parts C and D requirements directly adversely affected (or had the substantial likelihood of adversely affecting) enrollees and warrants the imposition of a CMP. NWHS failed substantially:

- To carry out the terms of its contract with CMS (42 C.F.R. § 422.510(a)(1) and 42 C.F.R. § 423.509(a)(1));
- To comply with the requirements in Subpart M relating to grievances and appeals (42 C.F.R. § 422.510(a)(4)(ii) and § 423.509(a)(4)(ii));

Right to Request a Hearing

NWHS may request a hearing to appeal CMS's determination in accordance with the procedures outlined in 42 C.F.R. Parts 422 and 423, Subpart T. NWHS must send a written request for a hearing to the Departmental Appeals Board office listed below within 60 calendar days from receipt of this notice or by September 8, 2015. The request for hearing must identify the specific issues and the findings of fact and conclusions of law with which NWHS disagrees. NWHS must also specify the basis for each contention that the finding or conclusion of law is incorrect. The request should be sent to:

Civil Remedies Division
Department of Health and Human Services
Departmental Appeals Board
Medicare Appeals Council, MS 6132
330 Independence Ave., S.W.
Cohen Building Room G-644
Washington, D.C. 20201

A copy of the hearing request should also be sent to CMS at the following address:

Michael DiBella
Director, Division of Compliance Enforcement
Centers for Medicare & Medicaid Services
7500 Security Boulevard
Baltimore, MD 21244
Mail Stop: C1-22-06
Email: Michael.Dibella@cms.hhs.gov

If NWHS does not request an appeal in the manner and timeframe described above, the initial determination by CMS to impose a CMP will become final and due on September 9, 2015. NWHS may choose to have the penalty deducted from its monthly payment, transfer the funds electronically, or mail a check to CMS. To notify CMS of your intent to make payment and for instructions on how to make payment, please call or email the enforcement contact provided in the email notification.

Please note that further failures by NWHS may result in additional applicable remedies available under law, up to and including contract termination, the imposition of intermediate sanctions, penalties, or other enforcement actions as described in 42 C.F.R. Parts 422 and 423, Subparts K and O.

If NWHS has any questions about this notice, please call or email the enforcement contact provided in the email notification.

Sincerely,

/s/

Gerard J. Mulcahy
Director
Medicare Parts C and D Oversight and Enforcement Group

cc: Tod Anderson, CMS/ CMHPO/Region VIII
Anne Kane, CMS/ CMHPO/Region VIII
Mark McMullen, CMS/ CMHPO/Region VIII