

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: (pfrawley@fideliscare.org)

Rev. Patrick J. Frawley
President and Chief Executive Officer
New York State Catholic Health Plan, Inc.
95-25 Queens Blvd., 8th Floor
Rego Park, NY 11374

Re: 2012 Program Audit – Notice of Audit Closure for Medicare Advantage and/or Standalone Prescription Drug Plan Contracts: H3328

Dear Rev. Patrick J. Frawley:

On January 14, 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, Effectuation Timeliness, Condition ii.** - NYSCHP did not pay the claim within 30 days for non-contracted providers or 60 days for overall claims. Additionally, NYSCHP did not pay interest on non-contracted provider claims that were older than 30 days. This condition could not be validated as corrected because 4 of 5 cases reviewed during the validation failed for this issue (ET-6, ET-8, ET-9, and ET-10).
- 2. Part C Organization Determinations and Appeals, Appropriateness of Clinical Decision-Making, Condition ii.** - NYSCHP's denial notice did not include the specific reason for the denial. This condition could not be validated as corrected because 6 of 9 cases reviewed during the validation failed for this issue (CDM-1, CDM-2, CDM-3, CDM-4, CDM-8, and CDM-9).
- 3. Part C Organization Determinations and Appeals, Appropriateness of Clinical Decision-Making, Condition vii.** - NYSCHP did not provide sufficient evidence that appeal rights were provided to beneficiaries in denial notifications. This condition could not be validated as corrected because 5 of 5 cases reviewed during the validation failed for this issue (CDM-10, CDM-11, CDM-12, CDM-13, and CDM-14).
- 4. Part C Organization Determinations and Appeals, Appropriateness of Clinical Decision-Making, Condition viii.** - NYSCHP did not send reconsideration denial upholds to the independent review entity (IRE). This condition could not be validated as corrected because 2 of 5 cases reviewed during the validation failed for this issue (CDM-16 and CDM-19).
- 5. Part C Organization Determinations and Appeals, Appropriateness of Clinical Decision-Making, Condition xi.** - NYSCHP failed to identify a request for an appeal. This condition could not be validated as corrected because 3 of 15 cases reviewed during the validation failed for this issue (GRV-1, GRV-2 and GRV-9).
- 6. Part C Organization Determinations and Appeals, Appropriateness of Clinical Decision-Making, Condition xii.** - NYSCHP did not process an appeal within 60 days. This condition could not be validated as corrected because 2 of 5 cases reviewed during the validation failed for this issue (CDM-15 and CDM-16).
- 7. Part C Access to Care, CTM Complaints, Condition ii.** - NYSCHP did not follow CMS non-contracted provider claims payment requirements to pay the claim within 60 days and to pay interest on non-contracted provider claims that are older than 30 days. This condition could not be validated as corrected because 3 of 13 cases reviewed during the validation failed for this issue (ET-8, ET-9, and ET-10).
- 8. Effective System for Routine Monitoring, Auditing and Identification of Compliance Risks Condition i.** - The evidence provided does not support that a system was in place for monitoring and auditing the organization's compliance program effectiveness. This condition could not be validated as corrected as NYSCHP has not yet performed an audit of the compliance program's effectiveness.

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

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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. Joaquin Clinton-Clemens at 212-616-2364 or via email at Joaquin.Clinton-Clemens@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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