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

September 11, 2014

Mr. Todd Meek
President
SilverScript Insurance Co.
9501 E. Shea Blvd
Scottsdale, AZ 85260

Re: Notice of Imposition of Civil Money Penalty for Prescription Drug Plan Contract Number: S5766

Dear Mr. Meek,

Pursuant to 42 C.F.R. § 423.752(c)(1) and § 423.760(b), the Centers for Medicare & Medicaid Services (CMS) is providing notice to SilverScript Insurance Company (SSIC), who recently acquired CareFirst, Inc. contract number S5766 (CareFirst) in July of 2014, that CMS has made a determination to impose a civil money penalty (CMP) in the total amount of **$20,700** for Prescription Drug Plan Contract Number: S5766.

CMS has determined that CareFirst failed to provide its enrollees with Medicare benefits in accordance with CMS requirements. A Medicare Prescription Drug Plan sponsors' central mission is to provide Medicare beneficiaries with prescription drug benefits within a framework of Medicare requirements that provide plan enrollees with a number of protections.

Summary of Noncompliance

CMS conducted an audit of CareFirst's Medicare operations from March 31, 2014 through April 11, 2014. CMS auditors reported in the Medicare Advantage & Prescription Drug Program Audit report issued July 16, 2014, that CareFirst failed to comply with Medicare requirements related to Part D coverage determinations, appeals, and grievances in violation of 42 C.F.R. Part 423, Subpart M. CareFirst's failures in these areas were systemic and resulted in enrollees experiencing inappropriate delays or denials in receiving covered benefits and increased out-of-pocket costs.

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

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 to which the enrollee believes he or she is entitled. Sponsors are required to classify general complaints about benefits or the sponsor's operations or activities as grievances. Sponsors are required to classify complaints about coverage for drugs as coverage determinations. It is critical for a sponsor to properly classify each complaint as a grievance or a coverage determination or both. Improper classification of a 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 drugs.

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

If the coverage determination is adverse (not in favor of the enrollee), the enrollee has the right to file an appeal. The first level of appeal - called a redetermination – is handled by the plan sponsor and must be conducted by a physician who was not involved in the 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 coverage determinations and appeals. CMS has a beneficiary protection 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 D Coverage Determinations, Appeals, and Grievances

CMS identified serious violations of Part D coverage determination, appeal, and grievance requirements that resulted in CareFirst's enrollees experiencing inappropriate denials or delays in access to drugs. CareFirst's violations include:

1. Failure to effectuate and/or notify enrollees, or their prescribers, of its decision within the appropriate timeframe for expedited and standard coverage determinations, redeterminations, or for an exceptions request. This is in violation of 42 C.F.R. § § 423.568(b); § 423.572(a); § 423.572(b); § 423.590(a); § 423.590(d); and § 423.636(a); and IOM Pub. 100-18 Medicare Prescription Drug Benefit Manual, Chapter 18, Sections 40.2, 40.3.3, 40.3.4, 40.3.5, 50.4, 50.6, 70.7, 70.9.3, 70.9.4, 130.2.1 and 130.2.2.

2. Failure to demonstrate sufficient outreach to the provider or beneficiary to obtain additional information necessary to make an appropriate clinical decision. This is in violation of 42 C.F.R. § 423.566(a) and § 423.586; and IOM Pub. 100-18 Medicare Prescription Drug Benefit Manual, Chapter 18, Sections 10.2, 30.2.1.3, 30.2.2.3, 70.5 and 70.7.

Basis for Civil Money Penalty

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

- To carry out the terms of its contract with CMS (42 C.F.R. § 423.509(a)(1)); and
- To comply with the requirements in Subpart M relating to grievances and appeals (42 C.F.R. § 423.509(a)(5)).

Right to Request a Hearing

SSIC 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. SSIC 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 November 11, 2014. The request for hearing must identify the specific issues and the findings of fact and conclusions of law with which SSIC disagrees. SSIC 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 SSIC 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 November 12, 2014. SSIC 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 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 SSIC 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: Nancy O'Connor, CMS/ CMHPO/Region III
Tamara Mccloy, CMS/ CMHPO/Region III
Kathleen Dombrowski, CMS/ CMHPO/Region III