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

March 21, 2024

Mr. Stephen Ringel
President
CareSource Ohio, Inc.
230 North Main Street
Dayton, OH 45402

Re: Notice of Imposition of Civil Money Penalty for Medicare-Medicaid Plan Contract Number: H8452

Dear Mr. Ringel:

Pursuant to Section 5.3.14 of the MyCare Ohio contract and Article XI of the Part D Addendum , 42 C.F.R. §§ 422.752(c)(1), 422.760(c), 423.752(c)(1), and 423.760(c), the Centers for Medicare & Medicaid Services (CMS) is providing notice to CareSource Ohio, Inc. (CareSource), that CMS has made a determination to impose a civil money penalty (CMP) in the amount of **$27,898** for Medicare-Medicaid Plan (MMP) Contract Number H8452.

An MMP organization's primary responsibility is to provide Medicare enrollees with medical services and prescription drug benefits in accordance with Medicare requirements. CMS has determined that CareSource failed to meet that responsibility.

Summary of Noncompliance

CMS conducted an audit of CareSource's Medicare operations from June 5, 2023, through June 26, 2023. In a program audit report issued on November 20, 2023, CMS auditors reported that CareSource failed to comply with Medicare requirements related to Medicare-Medicaid service authorization requests, appeals, and grievances in violation of 42 C.F.R. Part 422, Subpart M and Sections 2.1.3 and 2.10.3.2.1 of the MyCare Ohio contract. Two (2) failures were systemic and adversely affected, or had the substantial likelihood of adversely affecting, enrollees. The enrollees may have experienced, or likely experienced delayed access to medical services or items, appeal rights, or increased out-of-pocket costs.

CMS reviews audit findings individually to determine if an enforceable violation has occurred warranting a CMP. CMPs are calculated and imposed when a finding of non-compliance adversely affected or had a substantial likelihood of adversely affecting enrollees. The determination to impose a CMP on a specific finding does not correlate with the MMP's overall audit performance.

Medicare-Medicaid Service Authorization Requests, Appeals, and Grievances Requirements

Service Requests and Reconsiderations
(42 C.F.R. §§ 422.566, 422.568, 422.574, 422.580, 422.582(d) & (f), and 482.584(d) &(g); and Sections 2.1.3 and 2.10.3.2.1 of the MyCare Ohio contract)

A service authorization request is when an enrollee, provider, or legal representative of a deceased enrollee requests coverage for an item or service with a Medicare-Medicaid Plan (MMP). Each MMP organization must have a procedure for making timely service authorization determinations regarding the benefits an enrollee is entitled to receive under an MMP plan, including basic benefits, mandatory, and optional supplemental benefits, and the amount, if any, that the enrollee is required to pay for a health service.

A reconsideration consists of a review of an adverse service authorization, the evidence, and findings upon which it is based, and any other evidence the parties submit, or the MMP organization or CMS obtains. A physician may make a request for a reconsideration on behalf of the enrollee and the physician is not required to provide an Appointment of Representative (AOR) form in order to make that request.

Denials of Payment Requests from Non-Contract Providers
(42 C.F.R. §§ 422.568(e) and 422.2267(e)(27); and Sections 2.1.3, 2.10.3.2.1, and 2.12.1 of the MyCare Ohio contract)

If a sponsor denies a request for payment from a non-contracted provider, the sponsor must notify the non-contracted provider with a specific reason for the denial and provide a description of the appeals process including a Waiver of Liability (WOL) form or link. The WOL form when signed by the non-contracted provider holds the enrollee harmless regardless of the outcome of the appeal. If non-contracted providers do not receive information from the sponsor on the appeals process, then enrollees are put at risk for being held financially liable for denied services.

Violations Related to Medicare-Medicaid Service Authorization Requests, Appeals, and Grievances

1) CMS determined that CareSource failed to provide non-contract providers with denial notices that included the applicable appeal rights. One of CareSource's claims processing contractors did not have the designated appeals rights correctly programed to appear on its evidence of payment (EOP) statements. As a result, non-contract providers were not aware of the appeals process and there is a substantial likelihood enrollees may have been inappropriately held financially liable for medical items or services. This failure violates 42 C.F.R. § 422.568(e), and MyCare Ohio contract, Sections 2.1.3 and 2.10.3.2.1.

2) CMS determined that CareSource improperly dismissed reconsiderations requested by physicians acting on behalf of enrollees because CareSource inappropriately required Appointment of Representative forms for these requests prior to processing. CareSource's procedures did not correctly instruct staff on processing reconsiderations

when parties legally authorized to make such requests did so on behalf of enrollees. As a result, CareSource did not process the reconsideration requests causing delays in access to medical items or services and/or appeal rights. This failure violates 42 C.F.R. § 422.580, § 422.582(d) & (f), § 482.584(d) & (g), and MyCare Ohio contract, Sections 2.1.3, 2.10.3.2.1, and 2.10.3.5.

Basis for Civil Money Penalty

Pursuant to Section 5.3.14.2.2 of the MyCare Ohio contract and 42 C.F.R. §§ 422.752(c)(1)(ii) and 423.752(c)(1)(ii), CMS may impose a CMP for any determination made under 42 C.F.R. §§ 422.510(a)(1) and 422.509(a)(1). Specifically, CMS may issue a CMP if an MMP has failed substantially to follow Medicare requirements according to its contract. Pursuant to 42 C.F.R. §§ 422.760(b)(1) and 423.760(b)(1), a penalty may be imposed for each determination where the deficiency has directly adversely affected (or has the substantial likelihood of adversely affecting) one or more enrollees. In addition, pursuant to 42 C.F.R. §§ 422.760(b)(2) and 423.760(b)(2), a penalty may be imposed for each enrollee directly adversely affected (or with the substantial likelihood of being adversely affected) by the deficiency.

CMS has determined that CareSource failed substantially:

- To carry out the terms of its contract with CMS (42 C.F.R. § 422.510(a)(1));
- To comply with the requirements in Subpart M relating to Part C grievances and appeals (42 C.F.R. § 422.510(a)(4)(ii)); and
- To comply with federal regulatory requirements related to MyCare Ohio contract with CMS (Section 5.3.14.1.6).

CareSource's violations of Part C requirements directly adversely affected (or had the substantial likelihood of adversely affecting) enrollees and warrants the imposition of a CMP.

Right to Request a Hearing

CareSource 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. CareSource must send a request for a hearing to the Departmental Appeals Board (DAB) office listed below by May 21, 2024.[1] The request for hearing must identify the specific issues and the findings of fact and conclusions of law with which CareSource disagrees. CareSource must also specify the basis for each contention that the finding or conclusion of law is incorrect.

The request should be filed through the DAB E-File System (https://dab.efile.hhs.gov) unless the party is not able to file the documents electronically. If a party is unable to use DAB E-File, it must send appeal-related documents to the Civil Remedies Division using a postal or commercial delivery service at the following address:

[1] Pursuant to 42 C.F.R. §§ 422.1020(a)(2) and 423.1020(a)(2), the organization must file an appeal within 60 calendar days of receiving the CMP notice.

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

Please see https://dab.efile.hhs.gov/appeals/to_crd_instructions for additional guidance on filing the appeal.

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

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

If CareSource 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 May 22, 2024. CareSource may choose to have the penalty deducted from its monthly payment or transfer the funds electronically. To notify CMS of your intent to make payment and for instructions on how to make payment, please email the enforcement contact provided in the email notification.

Impact of CMP

Further failures by CareSource to provide its enrollees with Medicare benefits in accordance with CMS requirements may result in CMS imposing additional remedies available under law, including contract termination, intermediate sanctions, penalties, or other enforcement actions as described in 42 C.F.R. Parts 422 and 423, Subparts K and O.

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

Sincerely,

/s/
John A. Scott
Director
Medicare Parts C and D Oversight and Enforcement Group

cc: Kevin Stansbury, CMS/CM/MOEG/DCE
Megan Mason, CMS/OPOLE
Doreen Gagliano, CMS/OPOLE
Chad Johnson, CMS/OPOLE
Stephanie Arriaga CMS/OPOLE