DEPARTMENT OF HEALTH & HUMAN SERVICES
Centers for Medicare & Medicaid Services
7500 Security Boulevard
Baltimore, Maryland 21244-1850

PROGRAM COMPLIANCE AND OVERSIGHT GROUP

February 20, 2013

VIA:
EMAIL (Paul.Marineau@jhsmiami.org)
AND FACSIMILE (305-355-2293)

Paul Marineau
Executive Director
Public Health Trust of Miami-Dade
1801 NW 9 Avenue, Suite 100
Miami, FL 33136
Phone: 786-466-8258

Re: Notice of Imposition of Civil Money Penalty for Medicare Advantage - Prescription Drug Plan Contract Number: H4155

Dear Mr. Marineau:

Pursuant to 42 C.F.R. § 422.752(c)(1), the Centers for Medicare & Medicaid Services (CMS) is providing notice to Public Health Trust of Miami-Dade (PHT), that CMS has made a determination to impose a civil money penalty (CMP) in the amount of $175,000 for Medicare Advantage - Prescription Drug (MA-PD) Plan Contract Number: H4155.

CMS has determined that PHT failed to provide its enrollees with services and benefits in accordance with CMS requirements. An MA-PD sponsor'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 an audit at PHT's Miami, Florida offices from November 5, 2012 through November 9, 2012. During the audit, CMS conducted reviews of PHT's operational areas to determine if PHT adhered to CMS regulations and guidelines. After conducting an extensive review, CMS auditors concluded that PHT substantially failed to comply with CMS

requirements governing Part C benefits and beneficiary protections set forth in 42 C.F.R. Part 422, Subpart C and Part C grievances, organization determinations, and appeals set forth in 42 C.F.R. Part 422, Subpart M. CMS found that PHT failed to ensure that organization determinations and plan reconsiderations, including expedited, pre-service reconsiderations, were processed timely. PHT failed to implement a meaningful process for grievances that includes resolving the grievance to the enrollee's satisfaction. In addition, PHT improperly imposed authorization restrictions for emergency medical services. Violations in these areas can result in enrollees experiencing delays or denials in receiving covered services and increased out-of-pocket costs. These violations directly adversely affected (or had the substantial likelihood of adversely affecting) PHT's enrollees.

Part C Grievance, Organization Determination and Appeal Relevant Requirements

Medicare enrollees have the right to contact their MA-PD ("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 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. *See* 42 C.F.R. § 422.564 (a) and (b). Sponsors are required to classify complaints about coverage for services as a request for an organization determination. *See* 42 C.F.R. §§ 422.564 (b) and 422.566(b). PHT failed to implement a meaningful process for grievances that includes resolving the grievance to the enrollee's satisfaction. *See* 42 C.F.R. §422.564(a). It is critical for a sponsor to properly classify each complaint as a grievance and/or an organization determination or reconsideration request. Failure to properly classify complaints, for example, processing a pre-service request for coverage of a medical service as a grievance instead of an organization determination, denies enrollees their due process rights and potentially delays access to medically necessary or life-sustaining services.

The enrollee, the enrollee's representative, or the enrollee's treating physician may request an organization determination, which is the first level of review and is conducted by the plan sponsor. *See* 42 C.F.R. § 422.566. If the plan expects to deny coverage based on a lack of medical necessity, the organization determination must be reviewed by a physician or other appropriate health care professional with sufficient medical and other expertise, including knowledge of Medicare coverage criteria. *See* 42 C.F.R. § 422.566(d). Coverage decisions must be made in accordance with Medicare coverage guidelines, Medicare covered benefits, and each sponsor's CMS-approved coverage policies. *See* 42 C.F.R. § 422.101(a-b). If the organization determination is adverse (not in favor of the enrollee), the enrollee has the right to file an appeal. *See* C.F.R. §422.578 and §422.580.

The first level of appeal is called reconsideration. Reconsiderations are processed by the plan sponsor and must be conducted by an individual who was not involved in making the organization determination. If the initial denial was based on a lack of medical necessity, the reconsideration must be conducted by a physician with expertise appropriate for the services at issue. *See* 42 C.F.R. § 422.590(g). Federal law requires Medicare health plans to notify the

enrollee of its decision in writing and promptly forward all adverse reconsideration determinations to an independent review entity (IRE) contracted by CMS. *See* 42 C.F.R. § 422.590(a-f) and 422.592.

Medicare health plans are required by regulation to make all coverage decisions as expeditiously as the enrollee's health condition requires, consistent with accepted standards of medical practice, and must have a system for determining the urgency of both standard and expedited requests for services. *See* 42 C.F.R. §§ 422.586(b), § 422.572(a), 422.590(a) and 422.590(d)(1). For example, if a physician has indicated that applying the standard timeframe for processing an organization determination or reconsideration could seriously jeopardize the life or health of the enrollee, then the sponsor must make its determination no later than 72 hours after receiving the request. *See* 42 C.F.R. §§ 422.570(a) and (c)(2)(ii), 422.572(a), 422.584 and 422.590(d). Reconsideration requests must be promptly forwarded to the IRE for adjudication when the plan fails to notify the enrollee of its reconsideration within the required timeframe. *See* 42 C.F.R. § 422.590(a-d), (f).

Other Relevant Requirements Related to Part C Benefits

There are certain services and benefits, such as emergency services, that do not require any prior authorization to obtain these services. The plan sponsor is financially responsible for these services regardless of whether the services are obtained within or outside the plan's network and regardless of whether there is a prior authorization for those services. *See* 42 C.F.R. §422.113(b)(2). If the plan inappropriately requires a prior authorization for emergency services and denies the service if no authorization is granted, there is a substantial risk that enrollees may be billed for significant hospital expenses for which they have no liability under the Medicare program.

Deficiencies Related to Part C Benefits, Grievances, Organization Determinations, and Appeals

CMS' audit identified multiple and serious violations of requirements in PHT's Part C benefits, grievances, organization determinations, and appeals operations. CMS found that these widespread violations were a result of a substantial lack of internal controls and adequately trained staff within PHT to handle the Part C organization determinations, appeals and grievances. PHT's violations include:

- Failure to ensure that organization determinations and plan reconsiderations, including expedited and pre-service reconsiderations, were processed and enrollees were notified of the decision within the required timeframes. This is in violation of 42 C.F.R. §§ 422.568(b) and 422.590(a-c)(d)(1).

- Failure to process physician requested expedited reconsiderations within the required timeframe. This is in violation of 42 C.F.R. §§ 422.584(a) and (c)(2)(ii) and 422.590(d).

- Failure to properly distinguish organization determinations and appeals from grievances. This is in violation of 42 CFR § 422.564(b).

- Failure to provide sufficient information in denial notices for enrollees to understand the reason(s) the request for coverage was denied. This is in violation of 42 CFR § 422.568(e).

- Improperly imposing prior authorization requirements for emergency medical services and the subsequent hospital admissions. This is in violation of 42 C.F.R. §§ 422.113(b)(2) and (c)(2).

- Failure to apply Medicare criteria (including regulatory and manual guidance or national and local coverage determinations) when making organization determinations. This is in violation of 42 CFR §422.101(b)(1).

- Failure to implement a meaningful process for resolving grievances. This is in violation of 42 C.F.R. § 422.564(a). In addition, PHT failed to provide enrollees with a written response to quality of care grievances that included a description of their right to file a complaint with the Quality Improvement Organization. This is in violation of 42 CFR 422.564(e)(3)(iii).

Basis for Civil Money Penalty

Pursuant to 42 C.F.R. § 422.752(c), CMS has determined that PHT's violations of Medicare Part C requirements are significant enough to warrant the imposition of a CMP. PHT failed substantially to carry out the terms of its contract with CMS, and failed to carry out its contract with CMS in a manner that is consistent with the effective and efficient implementation of the program. 42 C.F.R. § 422.510(a)(1) and (2).

Right to Request a Hearing

PHT may request a hearing to appeal CMS's determination in accordance with the procedures outlined in § 42 C.F.R. Part 422 Subpart T. PHT 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 April 22, 2013. 42 C.F.R. § 422.1006. The request for hearing must identify the specific issues and the findings of fact and conclusions of law with which PHT disagrees. PHT 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:

Patricia Axt, Director, Division of Compliance Enforcement
Centers for Medicare & Medicaid Services
7500 Security Boulevard
MAIL STOP: C1-22-06
Baltimore, MD 21244
Email: Trish.Axt@cms.hhs.gov
FAX: 410-786-6301

If PHT 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 April 23, 2013. PHT may choose to have the penalty deducted from its monthly payment, transfer the funds electronically, or mail a check to CMS.

CMS has determined that a CMP is the appropriate enforcement option for PHT's conduct at this time given that PHT has demonstrated progress in understanding the nature of the violations and provided CMS with a plan for correcting the violations. CMS will notify PHT of validation activities in the near future. CMS will be closely monitoring to determine if PHT has ongoing problems in the same areas, or experiences new violations in these or other areas. Further failures by PHT may result in additional applicable remedies available under law, up to and including the imposition of intermediate sanctions, additional penalties, or other contract actions as described in 42 C.F.R. Parts 422 and 423, Subparts K and O.

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

Sincerely,

/s/

Gerard J. Mulcahy
Acting Director
Program Compliance and Oversight Group

cc: Colleen Carpenter, CMS/CMHPO/Region IV
Jabal Chase, CMS/CMHPO/Region IV
Brandon Bush, CMS/CMHPO/Region IV