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

Ms. Emma DeVito
President & Chief Executive Officer
Village Senior Services Corporation
120 Broadway, Suite 2840
New York, NY 10271

Re: Notice of Imposition of Civil Money Penalty for Medicare Advantage-Prescription Drug
Contract Number: H2168

Dear Ms. DeVito:

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 Village Senior Services Corporation (VSSC) that CMS has made a determination to impose a civil money penalty (CMP) in the amount of **$10,208** for Medicare Advantage-Prescription Drug (MA-PD) Contract Number H2168.

An MA-PD 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 VSSC failed to meet that responsibility.

Summary of Noncompliance

CMS conducted an audit of VSSC's Medicare operations from July 17, 2023 through August 4, 2023. In a program audit report issued on November 9, 2023, CMS auditors reported that VSSC failed to comply with Medicare requirements related to Part C organization determinations and appeals in violation of 42 C.F.R. Part 422, Subpart C. One (1) failure was systemic and adversely affected, or had the substantial likelihood of adversely affecting, enrollees. The enrollees experienced or likely experienced delays in access to Part C required services.

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 MA-PD's overall audit performance.

Part C Organization Determination and Appeal Requirements
(42 C.F.R. Part 422, Subparts C and M)

A Part C organization determination is when an enrollee, provider, or legal representative of a deceased enrollee requests coverage or payment for an item or service with an MA organization. Each MA organization must have a procedure for making timely organization determinations regarding the benefits an enrollee is entitled to receive under an MA 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.

Medical coverage decisions must be made within the required timeframes and in accordance with Medicare coverage guidelines, Medicare covered benefits, each MA organization's CMS-approved coverage, and contracts with providers. This can be made by furnishing the benefits directly or through arrangements, or by paying for the benefits. If the MA organization incorrectly denies or delays coverage decisions, then enrollees may be inappropriately denied or delayed access to services or may be held financially liable for services already received.

Violation Related to Part C Organization Determinations and Appeals

CMS determined that VSSC inappropriately denied pre-service requests for required Part C services. Specifically, VSSC's staff failed to follow procedures for conducting provider outreach when additional information was necessary to make coverage determinations. VSSC's staff also failed to review enrollees' complete medical record or inconsistently applied medical criteria prior to making coverage decisions. As a result, the VSSC inappropriately denied coverage requests for medical services and enrollees experienced delays. This failure violates 42 C.F.R. §§ 422.100(c), 422.101(a), 422.101(b), 422.566(a) and Section 10.6 of the Parts C & D Enrollee Grievances, Organization/Coverage Determinations, and Appeals Guidance.

Basis for Civil Money Penalty

Pursuant to 42 C.F.R. §§ 422.752 (c)(1)(i) and 423.752(c)(1)(i), CMS may impose a CMP for any determination made under 42 C.F.R. §§ 422.510 (a)(1) and 423.509(a)(1). Specifically, CMS may issue a CMP if an MA-PD has failed substantially to follow Medicare requirements according to its contract. 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 affecting) by the deficiency.

CMS has determined that VSSC failed substantially to carry out the terms of its contract (42 C.F.R. § 422.510(a)(1)) because it substantially failed to comply with the requirements for making appropriate coverage decisions at 42 C.F.R. §§ 422.100(c), 422.101(a), 422.101(b) and Section 10.6 of the Parts C & D Enrollee Grievances, Organization/Coverage Determinations, and Appeals Guidance. Village Care of NYVSSC's violation 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

VSSC 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. VSSC 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 VSSC disagrees. VSSC 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:

Department of Health & Human Services
Departmental Appeals Board, MS 6132 Civil
Remedies Division
Medicare Appeals Council 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 VSSC 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.

VSSC 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 VSSC 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

[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.

in 42 C.F.R. Parts 422 and 423, Subparts K and O.

If VSSC 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
Douglas Edwards, CMS/OPOLE
Rachel Walker, CMS/OPOLE
Joaquin Clinton-Clemens, CMS/OPOLE