

Department of Health & Human Services
Centers for Medicare & Medicaid Services
7500 Security Boulevard, Mail Stop C-4-21-26
Baltimore, Maryland 21244-1850



Division of Medicare Health Plans Operation- Chicago ROV

CORRECTIVE ACTION PLAN

February 17, 2016

Thomas G. Wilson
Director, Medicare Compliance
CareSource
230 North Main Street
Dayton, OH 45402

VIA E-MAIL: Thomas.Wilson@CareSource.com

RE: Failure to meet network adequacy standards

Dear Mr. Wilson:

The Centers for Medicare & Medicaid Services (CMS) is issuing this request for a Corrective Action Plan (CAP) to CareSource for Medicare Advantage-Prescription Drug (MA-PD) contracts H1493 and H9162 regarding your failure to meet CMS's network adequacy standards.

Pursuant to 42 CFR §422.112(a)(1), MA-PD organizations must maintain a network of appropriate providers sufficient to provide adequate access to covered services to meet the needs of the population served. Each year, CMS publishes its current network adequacy criteria in the MA Health Services Delivery (HSD) Reference Tables and MA HSD Network Adequacy Criteria Guidance and Methodology and the (available for download at <http://cms.gov/Medicare/MedicareAdvantage/MedicareAdvantageApps/index.html>).

On December 4, 2015, CareSource first notified CMS of significant errors in the HSD tables submitted during the MA application process. CMS used the inaccurate HSD tables to approve the application, specifically in the determination that the network was sufficient to meet the health care needs of beneficiaries in the defined service area. On December 15, 2015, CareSource provided details regarding the initial report made on December 4, 2015. Specifically, CareSource identified that for contract H1493, there were network deficiencies in 5 counties and 9 specialty types. For contract H9162, CareSource identified network deficiencies in 10 counties and 8 specialty types.

On January 4, 2016, CareSource updated its initial report to disclose network deficiencies in 5 additional counties for contract H9162. CareSource also conveyed that network

inadequacies were used in the print and online provider directories (in spite of CareSource providing previous assurances that this situation did not occur). Provider directories must be accurate and up-to-date pursuant to 42 C.F.R. §422.111(a). By CareSource's own estimate, the print/online errors resulted in 10 newly enrolled beneficiaries choosing primary care physicians that were not actually part of CareSource's network.

On January 20, 2016, CareSource uploaded their latest HSD tables to the Network Management Module and CMS found network deficiencies that CareSource had not disclosed in their December 4, 2015 and January 4, 2016 reports. For contract H1493, CMS identified network deficiencies in 7 counties and 9 specialty types. For contract H9162, CMS identified network deficiencies in 13 counties and 10 specialty types.

Based on the errors identified above, your organization is out of compliance with Medicare Part C provider and facility network requirements pursuant to 42 CFR §422.112(a)(1). In addition, your organization is out of compliance with directories by misrepresenting your network in information used by beneficiaries in their plan selections.

Although CareSource has submitted a CAP to CMS, we are officially requesting that CareSource implement a detailed CAP. As part of this CAP, CareSource must have a network that meets all CMS network adequacy criteria for all specialties and counties for H1493 and H9162. CareSource should also address the actions listed below, plus any other additional items that CareSource identifies as necessary to correct this problem and prevent it from reoccurring. Because of the complexity and sensitivity of this matter, CMS will review materials and intermediary implementation steps throughout the process. Please provide and submit to your CMS Account Manager the following:

- A detailed root cause analysis and beneficiary impact for contracts H1493 and H9162. This should include data going back to open enrollment during the CY 2016 Annual Election Period.
- A description of the actions CareSource has taken and will take to correct the deficiencies described in this letter.
- A detailed description of the measures CareSource will employ to ensure continued compliance after the corrective actions are in place.
- A statement of assurance that CareSource will proactively, and in advance where possible, alert CMS of operational issues that may have a negative impact on beneficiary access to care or ability to rely upon the veracity of plan communications.
- A description of CareSource's policies and procedures that will be utilized to assist affected beneficiaries in obtaining non-network provider care. Specifically, will CareSource assist members in identifying/contacting non-contracted providers and arranging payment on their members' behalf? Or will beneficiaries be responsible for paying non-contracted providers directly and requesting reimbursement from CareSource? If the latter, please detail a timeline for reimbursing beneficiaries and what alternatives (if any) will be afforded members who are unable to pay providers out-of-pocket fees in advance for services.

- Sample signature pages for 10 provider and 10 facility contracts for your network. The requested names of providers and facilities will be provided by separate email correspondence.

CareSource has 30 days from the date of this letter to comply with all CAP requirements, including a network meeting CMS' criteria and an updated directory that reflects this contracted network. Following the 30 day period CMS will request another submission of HSD tables to verify network adequacy. If CareSource is relying on exceptions for any specialties or counties these exception requests must be approved prior to the submission of the HSD tables. Please send the above mentioned items to Andy Mathison, Account Manager, at andy.mathison@cms.hhs.gov.

CMS is issuing this compliance notice pursuant to 42 C.F.R. §422.510(c), which requires CMS to afford a sponsor at least 30 days to develop and implement a CAP to correct deficiencies before taking steps to terminate a sponsor's Medicare contract.

CMS has the authority to impose sanctions, penalties and other enforcement actions as described in Federal regulations at 42 CFR 422 Subpart O. Should your organization fail to develop, implement or complete its CAP, CMS may consider the imposition of intermediate sanctions (e.g., suspension of marketing and enrollment activities), civil money penalties, or termination.

Please be aware that this letter will be included in the record of your organization's past Medicare contract performance, which CMS will consider as part of our review of any application for new or expanded Medicare contracts your organization may submit. This letter is considered a Part C issue with beneficiary impact for past performance purposes. In determining the severity of this notice, CMS has considered as a mitigating factor your organization's efforts in self-reporting information concerning the non-compliant activity.

If you have any questions about this letter, please contact me directly at 312-353-0566.

Sincerely,



Heather Lang
Associate Regional Administrator
Division of Medicare Health Plans Operations

Cc:
Christine Reinhard, Part C Compliance Lead, CMS
Ellen Skirvin, CMS
Marty Abeln, CMS
Raymond Swisher, MA Branch Manager, CMS Chicago
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