

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



MEDICARE DRUG BENEFIT AND C & D DATA GROUP

December 13, 2012

Contract ID: H3337

Carolyn Angrisani
LIBERTY HEALTH ADVANTAGE, INC.
One Huntington Quadrangle
Suite 3N01
Melville NC 11747

CORRECTIVE ACTION PLAN (CAP) REQUEST

Delivered via email to Carolyn Angrisani at cangrisani@lhany.com

Dear Carolyn Angrisani:

The Centers for Medicare & Medicaid Services (CMS) is issuing this compliance notice to **LIBERTY HEALTH ADVANTAGE, INC.** concerning its failure, as indicated by its most recent low plan (or “star”) rating, to meet the administrative and management requirements that apply to Medicare Advantage organizations (MAOs) and stand-alone Medicare Prescription Drug Plan (PDP) sponsors. In particular, your organization’s score(s) established it as a poor performer, and CMS is requesting that your organization develop and implement a corrective action plan designed to ensure that it will achieve at least an “average” plan rating.

Medicare regulations at 42 C.F.R. § 422.503(b)(4)(ii) and §423.504(b)(4)(ii) require MAOs and PDP sponsors, respectively, to have administrative and management arrangements satisfactory to CMS, including personnel and systems sufficient for the organization to market and administer benefit plans and conduct utilization management and quality assurance activities consistent with Medicare requirements. The performance measures used to calculate an organization’s Part C or D Summary Plan Rating reflect a sponsor’s contract performance across multiple Medicare program requirements. A contracting organization’s administrative and management arrangements necessarily have a direct impact on its performance of a similarly broad range of program requirements. Therefore, CMS considers a low Part C or D Summary Plan Rating to be evidence that the sponsor has in place insufficient administrative and management arrangements to meet its obligations as a Medicare plan sponsor.

CMS has previously informed Part C and D contracting organizations that we consider a plan rating below three stars to be out of compliance with these obligations under the Medicare program. For example, in the preamble to our notice of proposed rulemaking published in the Federal Register on October 22, 2009, we stated that, “organizations and sponsors with less than ‘good’ ratings should expect to be the subject of our monitoring

and compliance actions.” Also, in the CY 2012 Call Letter, CMS stated that we would issue compliance notices each year to those organizations that received less than three stars and that those who received such a rating for three consecutive years should expect to have their contract performance closely evaluated by CMS to determine whether we should terminate the organization’s Medicare contract. Finally, in April 2012, CMS issued regulations that establish both the maintenance of at least three-star plan ratings as a Medicare program participation requirement and the failure to achieve a three-star rating for three consecutive years as a basis for contract termination. CMS notes that this is not the first year that your organization has earned a Part C summary rating of less than three stars.

On October 12, 2012, CMS released the CY 2012 Part C and D plan ratings on the Medicare Plan Finder tool on www.medicare.gov. CMS assigned sponsors separate Summary Plan Ratings for their Part C and Part D operations. Most MAOs were assigned both C and D Summary Plan Ratings. PDP sponsors received only a Part D Summary Plan Rating as did a number of MAOs for which CMS could not calculate a Part C rating. Your organization received the following Summary Plan Rating(s):

Part C Summary Rating 2.5

Be advised that CMS treats Summary Plan Ratings of below 3 stars for Part C operations and for Part D operations as two separate compliance issues even though they may be discussed in a single letter. For sponsors with low star ratings for both Part C and D operations, CMS will document the issues in our records as two separate CAP requests.

CMS analysis indicates that your organization’s unsatisfactory rating(s) is driven largely by its poor performance in the following measures:

- C02 - Colorectal Cancer Screening
- C05 - Glaucoma Testing
- C06 - Annual Flu Vaccine
- C09 - Monitoring Physical Activity
- C11 - Care for Older Adults – Medication Review
- C12 - Care for Older Adults – Functional Status Assessment
- C13 - Care for Older Adults – Pain Screening
- C17 - Diabetes Care – Blood Sugar Controlled
- C18 - Diabetes Care – Cholesterol Controlled
- C19 - Controlling Blood Pressure
- C24 - Getting Needed Care
- C25 - Getting Appointments and Care Quickly
- C27 - Overall Rating of Health Care Quality
- C28 - Overall Rating of Plan
- C29 - Care Coordination
- C30 - Complaints about the Health Plan
- C32 - Members Choosing to Leave the Plan
- C35 - Reviewing Appeals Decisions

CMS advises your organization to take steps to improve its operations in the areas identified above and bring its Summary Plan Rating(s) to a level that indicates at least average contract performance, compliant with Medicare requirements. Should your organization fail for three straight years to achieve at least a three-star rating, CMS may initiate action to terminate its Medicare contract.

CMS is not requiring a CAP submission from your organization. CMS will simply look at your organization's plan rating performance in the coming year to determine whether you took the necessary corrective action to achieve at least a three-star summary plan rating.

If you have any questions about this notice, please contact **Scott Nelson** at ***Scott.Nelson2@cms.hhs.gov***.

Sincerely,



Cynthia G. Tudor, Ph.D.
Director
Medicare Drug Benefit and
Part C & D Data Group

CC:

Scott Nelson, CMS
CARMEN AYALA-BLADT, CMS