

MEDICARE DRUG & HEALTH PLAN CONTRACT ADMINISTRATION GROUP

Corrective Action Plan

September 6, 2019

H7119

Mr. Rick Grindrod
Medicare Compliance Officer
Provider Partners Health Plan of Ohio
901 Elkridge Landing Rd
Suite 100
Linthicum Heights, MD 21090

Via Email: Rgrindrod@pphealthplan.com

RE: Failure to have a sufficient provider network

Dear Mr. Grindrod:

The Centers for Medicare & Medicaid Services (CMS) is issuing this determination for a Corrective Action Plan (CAP) to Provider Partners Health Plan of Ohio (PPHPO), Contract ID H7119, for its failure to have a sufficient provider network. As a result, CMS directs that PPHPO take corrective action to address the non-compliance.

Federal regulations at 42 C.F.R. §422.112(a)(1) require MA organizations to maintain and monitor a provider network that provides adequate access and meets the population served. 42 C.F.R. §422.112(a)(10) requires MA organization's networks meet the prevailing community pattern of care which is determined by the number and distribution of health care providers as well as the time and distance for member access to health care providers.

In determining whether an organization has a sufficient provider network, CMS has identified provider and facility specialty types that must meet CMS' published number, time, and distance standards for each county. CMS provides the HPMS Network Management Module, which allows organizations to determine whether their current network meets CMS requirements.

PPHPO submitted an initial application in February 2018 for a contract effective date of January 1, 2019. CMS reviewed PPHPO's provider network in June 2018 and determined your network was insufficient. A contract for January 1, 2019 was awarded, with the understanding that PPHPO would be compliant by January 1, 2019. In February 2019, CMS requested PPHPO

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upload their provider network once again. Another review was conducted to determine if PPHPO's network was adequate. The review identified a total of 62 failures for 37 provider types in six counties. Provider types that failed to meet CMS' requirements included primary care providers, cardiologists, urologists, and orthopedic surgeons.

The above findings support a determination by CMS that PPHPO failed to comply with the requirements at 42 CFR §422.112.

As a note, PPHPO will be non-renewing the six counties mentioned above for Contract Year 2020. However, based on PPHPO's failure to secure an adequate network for the six counties, CMS is requesting a detailed CAP. As part of this CAP, PPHPO should address the actions listed below, plus any other additional items that PPHPO 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. Further, our engagement throughout this process will provide CMS with the information we need to eventually close the CAP.

- Provide to CMS a detailed root cause analysis as to why PPHPO could not secure an adequate network by their February 2019 network submission.
- Provide a detailed description of how PPHPO will determine available providers, contact the providers and secure contracts in the future.
- Ensure access to specialty care by permitting enrollees to see out of network providers at in network cost sharing for counties/specialists that fail to have an adequate network.
- Make alternative arrangements if the number of network primary care providers is not sufficient to ensure access to medically necessary care.
- Provide a detailed description of how PPHPO will monitor their network to ensure the PPHPO continues to meet provider network adequacy requirements at all times.

CMS expects PPHPO to provide the CAP to your Account Manager Scott Beach at scott.beach@cms.hhs.gov by October 7, 2019. CMS is issuing this compliance notice pursuant to 42 C.F.R. §422.510(c), which requires CMS to afford a plan at least 30 days to develop and implement a corrective action plan to correct deficiencies before taking steps to terminate a plan's Medicare contract. While CMS is not obligated to grant a greater than 30-day cure period, we acknowledge that an extended period may be appropriate, depending on the nature of the correction required. CMS advises that, for any part of its timeline scheduled to be completed in more than 30 days, PPHPO provide a justification of the need for that additional time. CMS expects that the correction timeline will be no longer than absolutely necessary and will reflect an appropriate level of urgency in resolving this matter.

CMS has the authority to impose sanctions, penalties and other enforcement actions as described in Federal regulations at 42 CFR 423 Subpart O. Should your organization fail to develop,

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implement or complete its CAP, CMS may consider the imposition of intermediate sanctions (e.g., suspension of marketing and enrollment activities) or civil money penalties.

If you have any questions about this letter, please contact Kelley Ordonio at kelly.ordonio@cms.hhs.gov.

Sincerely,

A handwritten signature in black ink, which appears to read "Timothy G. Roe". The signature is written in a cursive, flowing style.

Timothy G. Roe

cc via email:

Scott Beach, Region 3
Christine Reinhard, Part C Compliance Lead
Kelley Ordonio