

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



**CENTER FOR MEDICARE**

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November 27, 2023

**Corrective Action Plan**

Contract ID: H4863

Parent Organization Name: Tennessee Rural Health Improvement Association

Legal Entity Name: TRH HEALTH INSURANCE COMPANY

Thomas Tutaj  
Medicare Compliance Officer  
P.O. Box 313  
Columbia, TN 38402

VIA EMAIL: [ttutaj@fbhp.com](mailto:ttutaj@fbhp.com)

**RE: Failure to maintain an accurate online provider directory**

Dear Thomas Tutaj:

The Centers for Medicare & Medicaid Services (CMS) is issuing this Corrective Action Plan (CAP) to TRH HEALTH INSURANCE COMPANY, which operates contract H4863, regarding the Medicare Advantage Organization's (MAO's) failure to maintain an accurate online provider directory.

Pursuant to 42 C.F.R. §§ 422.111(a)(2) and (b)(3)(i) and 422.2267(e)(11), MAOs must provide clear and accurate information to beneficiaries regarding the provider network that a member can reasonably access. Regulations at 42 C.F.R. §§ 422.111(h)(2)(i)-(ii) and 422.2265(b)(3)-(4) also require an MAO to maintain a website which contains a listing of providers for members. CMS's Medicare Advantage and Section 1876 Cost Plan Provider Directory Model and Instructions detail the specific data elements required to be included in provider directories.

CMS performed a monitoring review of your online provider directory during the month(s) of August, 2023. The review consisted of calling 80 providers and verifying the information contained in your online provider directory. We provided your organization with an opportunity to review CMS's findings, concur or non-concur with those findings, and provide documentation for non-concurrence. Following your response, CMS made final determinations.

The results of our review showed that your organization failed to ensure accurate information in your online provider directory. Therefore, your organization is out of compliance with Part C requirements. CMS calculated performance scores based on the number of deficiencies, the egregiousness of those findings, and the total number of locations reviewed.

As previously communicated, CMS employed compliance discretion in cases where an MAO utilizes the National Plan and Provider Enumeration System (NPPES). We reviewed the deficiencies in your online provider directory against the data in NPPES and excluded the deficiency if the data matched. Your findings resulted in a deficiency score of 54.80%. Please note, if CMS had not taken NPPES into consideration, your deficiency score would have been 65.47%.

CMS will send a spreadsheet via email showing your specific deficiencies and scores. Your organization will need to correct your provider directory, as well as reach out to each applicable provider and request that they correct the NPPES data. Based on this score, CMS is issuing this CAP. Please ensure that your organization's provider directory information is accurate and up to date.

CMS requests that your organization implement a detailed CAP. As part of this CAP, your organization should address the steps your organization will take to improve provider directory accuracy and the actions your organization will take to prevent inaccuracies from reoccurring. Because of the complexity and sensitivity of this matter, CMS will review materials and intermediary implementation steps throughout this process. Further, our engagement throughout this process will provide us with the information we need to eventually close the CAP.

By December 16, 2023, please send your CAP to your Account Manager. CMS is issuing this compliance notice pursuant to 42 C.F.R. § 422.510(c), which requires CMS to afford an organization at least 30 days to develop and implement a CAP to correct deficiencies before taking steps to terminate an organization'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, your organization 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.

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. The information in this letter is considered a Part C issue for past performance purposes. CMS notes that we are issuing this compliance notice based exclusively on information that we obtained from sources other than your organization's own self-disclosure.

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, 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 notice, please contact Kim Levin at [Kimberlee.Levin@cms.hhs.gov](mailto:Kimberlee.Levin@cms.hhs.gov) and copy your CMS account manager.

Sincerely,



Timothy G. Roe, Director  
Division of Surveillance, Compliance and Marketing  
Medicare Drug and Health Plan Contract Administration Group

CC via email:

Christine Reinhard, CMS

Kim Levin, CMS

SHANNON COMAGE, CMS