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

July 31, 2014

E-MAIL: jestevez@accessmedicareny.com

Dr. Juan Estevez
Chief Executive Officer
Cuatro LLC
93-20a Roosevelt Ave., Suite 3C
Jackson Heights, NY 11372
718-899-0051

Re: 2013 Program Audit - Notice of Audit Closure for Medicare Advantage and Standalone Prescription Drug Plan Contract: H4866

Dear Dr. Estevez:

On December 20, 2013, the Centers for Medicare & Medicaid Services (CMS) issued the final audit report to your organization for the above-referenced Medicare Advantage and/or Prescription Drug Plan contracts. The audit evaluated your organization's compliance with CMS requirements in the following areas:

1. Part D Formulary and Benefit Administration
2. Part D Coverage Determinations, Appeals and Grievances
3. Part C Organization Determinations, Appeals, Grievances and Dismissals
4. Parts C & D Compliance Program Effectiveness
5. Part C and Part D Outbound Enrollment Verification Calls (OEV)

Your organization was afforded 90 calendar days from the report date to provide data and documents to CMS to demonstrate and attest that all of the deficiencies in the audit report were sufficiently corrected and not likely to recur. CMS reviewed your evidence of correction submission and also conducted a review to validate the implementation of required corrective actions and immediate corrective actions.

This notice is to inform you that based on the evidence provided by your organization and the validations conducted, you have corrected all conditions except:

The following conditions still remain from the audit report:

1. **Part D Coverage Determinations, Appeals and Grievances, Appropriateness of Clinical Decision-Making, Condition iii** - Sponsor failed to either authorize payment and/or reimburse the beneficiary timely upon making a favorable reimbursement redetermination. This condition

was not validated as corrected as Sponsor failed to develop a written policy and procedure for processing and effectuating requests for reimbursements or tools for monitoring this process.

2. **Compliance Program Effectiveness, Effective System for Routine Monitoring, Auditing and Identification of Compliance Risks, Condition ii** - Sponsor did not provide evidence that it audits the effectiveness of the compliance program at least annually and that the results are shared with the governing body. This condition was not validated as corrected as Sponsor failed to conduct an audit of the effectiveness of the Compliance Program. Instead, Sponsor administered a survey to different internal departments to attempt to gauge its compliance program's effectiveness. CMS requirements state that a self-assessment tool, dashboard, or scorecard can be used in support of a compliance program effectiveness audit, but not as an alternative.

The following new condition was identified during the validation:

1. **Part C Organization Determinations, Appeals, Grievances and Dismissals, Appropriateness of Clinical Decision-Making** - Sponsor's denial notices failed to provide the beneficiaries with a denial rationale written in a manner that they could understand. Failure to include information regarding the denial in a manner understandable to the beneficiary may impair the beneficiary's ability to mount an adequate appeal and could result in a delay in/denial of care and/or financial hardship (CDM-3, CDM-8, CDM-9, and CDM-10).

The following observations were noted during the validation:

1. **Part D Coverage Determinations, Appeals and Grievances, Appropriateness of Clinical Decision-Making** - Sponsor does not document training of staff on new work instructions. Sponsor should implement procedures to ensure documentation of staff training is performed and maintained, to include what was discussed with attendees and attendance logs.

2. **Part D Coverage Determinations, Appeals and Grievances, Grievances and Call Logs** - Sponsor's documentation of beneficiary complaints was incomplete and did not fully describe the issues grieved. The failure of Sponsor to obtain specifics related to a previous written communication and medication discussed in the grievance led to the Sponsor referring the beneficiaries to the prescriber when possible coverage determinations were being requested. Sponsor should ensure information is properly obtained, documented, and investigated to ensure beneficiary complaints are adequately addressed (CL-ALT2 and CL-8).

3. **Part C Organization Determinations, Appeals, Grievances and Dismissals, Appropriateness of Clinical Decision-Making** - Sponsor did not make the payment decision and notify the beneficiary within 60 days after the receipt of the organization determination request. Beneficiaries may be unaware of the status of the organization determination, and/or appeal rights, and could potentially experience a lapse in coverage, a delay in access to care, and/or financial hardship. This issue was noted in Sponsor's 2013 program audit as Effectuation Timeliness, Condition iv, which passed the validation. However, the issue was still noted as present in one validation sample. Based on what was observed during Sponsor's validation, the

cause of the exception noted during the validation was not indicative of corrective action plans that are not effective (CDM-4).

4. **Part C Organization Determinations, Appeals, Grievances and Dismissals, Appropriateness of Clinical Decision-Making** - Sponsor's universe submission included multiple inaccuracies, resulting in the selection of 4 alternate samples among the 10 samples selected. This resulted in the review of 14 cases that ultimately yielded a sample of 8. Sponsor should ensure appropriate validation of data is performed in response to CMS audit requests.

5. **Part C Organization Determinations, Appeals, Grievances and Dismissals, Appropriateness of Clinical Decision-Making** - Despite being specifically requested, Sponsor did not provide a copy of the provider denial notice. As such, the following compliance elements, not directly related to the conditions being validated, could not be assessed for 5 cases sampled: the provision of non-contracted provider appeal rights, timeliness of provider notice and whether inappropriate beneficiary liability was assigned. Sponsor should ensure it is responsive to all CMS audit requests (CDM-4, CDM-5, CDM-8, CDM-9, and CDM-10).

Your validation provided CMS with a reasonable assurance you are in compliance with program requirements tested during the audit. However, CMS will require heightened monitoring of the conditions and/or observations noted above to ensure Sponsor continues to implement effective correction. Your Account Manager will contact you to address these issues.

CMS is closing your audit.

CMS considers your compliance program's effectiveness to be essential in preventing, detecting and responding to potential non-compliance and fraud, waste, and abuse. Therefore, CMS expects your organization to continue monitoring the effectiveness of the corrective actions you have implemented and to continue to measure and improve the effectiveness of your compliance program. In addition, your Account Manager will continue to monitor and oversee your operations and compliance program to ensure that your organization is in compliance with all CMS requirements.

If you have any questions concerning this notice, please contact Mr. Darryl Brookins at 410-786-7542 or via email at Darryl.Brookins@cms.hhs.gov.

Sincerely,

/s/

Tawanda Holmes
Director, Division of Audit Operations
Medicare Part C and D Oversight and Enforcement Group