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

June 13, 2014

E-MAIL: (sapera@nychhc.org)

Dr. Arnold Saperstein
Chief Executive Officer\President
New York City Health & Hospitals Corp.
160 Water Street, 4th Floor
New York, New York 10038
Telephone Number: 1-212-908-8600 Ext. 8590

Re: 2012 Program Audit – Notice of Audit Closure for Medicare Advantage and/or Standalone Prescription Drug Plan Contracts: H0423

Dear Dr. Saperstein:

On January 30, 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 and Appeals
3. Part D Grievances
4. Part C Organization Determinations and Appeals
5. Part C Grievances
6. Part C Access to Care
7. Parts C & D Agent/Broker Oversight
8. Parts C & D Compliance Program Effectiveness
9. Parts C & D Enrollment and Disenrollment
10. Part D Late Enrollment Penalty

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 and Appeals, Appropriateness of Clinical Decision-Making, Condition iii. - MetroPlus' denial letters did not include an adequate rationale or accurate information specific to each case and did not clearly document next steps to obtain coverage or formulary alternatives. This condition was not validated as corrected because the same condition was identified in 2 of 5 samples reviewed during the validation (CDM-6 and CDM-8).
2. Part C Organization Determinations and Appeals, Appropriateness of Clinical Decision Making, Condition iv. - MetroPlus' denial notification to the beneficiary failed to provide a denial rationale that was specific to the beneficiary's individual case and written in a manner that the beneficiary could understand. This condition was not validated as corrected because the same condition was identified in 4 of 5 samples reviewed during the validation (CDM-1, CDM-2, CDM-3, and CDM-4)
3. Compliance Program Effectiveness, Element IX. First Tier, Downstream, and Related Entities (FDR) Oversight, Condition iv. - MetroPlus did not provide evidence of monitoring for 3 of 5 FDRs sampled. This condition was not validated as corrected because MetroPlus did not provide evidence that it has implemented processes for monitoring and auditing its FDRs compliance with CMS program requirements.
4. Compliance Program Effectiveness, Element IX. First Tier, Downstream, and Related Entities (FDR) Oversight, Condition v. - MetroPlus did not provide evidence that it performed any audits of its FDRs' compliance with CMS requirements in 2011 or 2012. This condition was not validated as corrected because MetroPlus did not provide evidence that it has implemented processes for monitoring and auditing its FDRs compliance with CMS program requirements.

The following observations:

1. Part C Organization Determinations and Appeals, Effectuation Timeliness and Appropriateness of Clinical Decision Making - MetroPlus does not document the time of receipt for expedited pre-service organization determination requests. As a result, MetroPlus cannot ensure that all expedited pre-service organization determination requests are adjudicated within 72 hours of receipt. MetroPlus should implement processes that capture the time of receipt of all expedited pre-service organization determination requests.
2. Part C Organization Determinations and Appeals, Appropriateness of Clinical Decision Making - MetroPlus did not make its determination and notify the enrollee (and the physician involved, as appropriate) of its decision within 72 hours after receiving an expedited request for an organization determination. CMS observed that MetroPlus had implemented corrective actions to address this issue which was observed during the audit. However, it was noted during the validation that some organization determination requests were being initially processed

incorrectly as Medicaid requests and then subsequently re-evaluated as Medicare Advantage requests which caused untimely determinations. MetroPlus should strengthen its internal controls to address this vulnerability to ensure that all expedited organization determination requests are adjudicated timely.

3. Compliance Program Effectiveness, Element VI. Effective System for Routine Monitoring, Auditing and Identification of Compliance Risks - MetroPlus did not provide all accompanying documentation to support the auditing and monitoring it conducted of its Medicare Part C and Part D program, CMS did observe that MetroPlus has a system in place for auditing and monitoring its Part C and Part D program and that auditing and monitoring is occurring. However, CMS still has some concerns about how MetroPlus is developing its auditing and monitoring plans when it does not have evidence of an organization risk assessment for its Part C and Part D operations.

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 Janis Remer at 212-616-2363 or via email at janis.remer@cms.hhs.gov.

Sincerely,

/s/

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