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

October 14, 2014

E-MAIL: curranp@careoregon.org

Mr. Patrick Curran
Chief Executive Officer
CareOregon, Inc.
315 SW 5th Avenue
Suite 900
Portland, OR 97204

Re: 2012 Program Audit – Notice of Audit Closure for Medicare Advantage and/or Standalone Prescription Drug Plan Contracts: H5859

Dear Mr. Curran:

On February 25, 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. Enrollment and Disenrollment
10. Late Enrollment Penalty (LEP)

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:

1. Part D Coverage Determinations and Appeals, Appropriateness of Clinical Decision-Making, Condition ii. – In 2 cases reviewed during the audit, CareOregon issued a denial letter that included incorrect information specific to the individual case. This condition could not be validated as corrected because 2 of 6 cases reviewed during the validation failed for this issue (CDM-6 and CDM-10).
2. Part D Coverage Determinations and Appeals, Appropriateness of Clinical Decision-Making, Condition iii. – In 6 cases reviewed during the audit, CareOregon made a negative coverage determination without sufficient outreach to the prescriber or beneficiary to obtain additional information necessary to make an appropriate clinical decision. This condition could not be validated as corrected because 3 of 6 cases reviewed during the validation failed for this issue (CDM-3, CDM-6, and CDM-12).
3. Part D Coverage Determinations and Appeals, Appropriateness of Clinical Decision-Making, Condition vi. – In 2 cases reviewed during the audit, CareOregon inappropriately denied a request for a coverage determination. This condition could not be validated as corrected because 2 of 6 cases reviewed during the validation failed for this issue (CDM-6 and CDM-13).
4. Part D Grievances, Condition i. - In 2 cases reviewed during the audit, CareOregon did not address or did not appropriately address all issues raised in the grievance. This condition could not be validated as corrected because the 1 case reviewed during the validation failed for this issue (GRV-1).
5. Part C Organization Determinations and Appeals, Appropriateness of Clinical Decision-Making, Condition ix. – This condition is no longer cited in CMS audits due to a policy change in the revised Medicare Managed Care Manual, dated 4/20/12, Section 60.1.1.
6. Part C Organization Determinations and Appeals, Appropriateness of Clinical Decision-Making, Condition x. – While this condition was included in the validation, upon review, CMS determined incorrect samples were selected to validate this condition. This condition remains open. Your Account Manager will contact you to ensure the CAP has been successfully implemented.
7. Compliance Program Effectiveness, Element VI, Effective System for Routine Monitoring, Auditing & Identification of Compliance Risks, Condition i. - CareOregon did not have a system for auditing and routine monitoring of compliance program effectiveness. This condition could not be validated as corrected because CareOregon failed to establish monitoring and auditing activities conducted by the Compliance Department as part of an effective compliance program, separate from those activities conducted by operational areas.
8. Compliance Program Effectiveness, Element VI, Effective System for Routine Monitoring, Auditing & Identification of Compliance Risks, Condition ii. - CareOregon's evidence provided does not support that a system was in place for monitoring compliance with CMS requirements. This condition could not be validated as corrected because CareOregon failed to establish monitoring and auditing activities conducted by the Compliance Department as part of an effective compliance program, separate from those activities conducted by operational areas.

Applicable transition findings, if any, were covered by Medicare Drug Benefit and C & D Data Group's (MDBG) Transition Monitoring Program Analysis (TMPA). The results of that analysis and any resulting action(s) will be communicated to you by MDBG and your account manager.

The following observations:

1. Part D Coverage Determinations and Appeals, Appropriateness of Clinical Decision-Making - CareOregon did not notify the beneficiary or the prescriber of its decision within 7 days of receipt of the standard redetermination request. CareOregon lacks adequate controls to ensure that beneficiaries are notified of the decision of redetermination within the required time frame. The beneficiary and their prescriber may be confused regarding the status of the redetermination, and/ or appeal rights. The beneficiary could potentially experience a lapse in coverage, and a delay in access to care.
2. Part D Coverage Determinations and Appeals, Appropriateness of Clinical Decision-Making – CareOregon did not appropriately auto-forward an expedited coverage redetermination exceeding the CMS required timeframe to the IRE for review and disposition. CareOregon failed to recognize when the initial redetermination request was received until a follow up request was received. CareOregon lacks adequate controls for tracking incoming requests. The failure to forward cases to the IRE in a timely manner can result in delays of access to care. The beneficiary may also be confused regarding the status of the determination.
3. Part D Coverage Determinations and Appeals, Appropriateness of Clinical Decision-Making - CareOregon made an inappropriate denial when processing a coverage determination. CareOregon lacks adequate controls to ensure that determination decisions are appropriate and based upon the most current CMS-approved formulary. The beneficiary's request was inappropriately denied and the beneficiary experienced an unnecessary delay and/or inability to access care. This may have resulted in a financial hardship for the beneficiary.
4. Part D Coverage Determinations and Appeals, Appropriateness of Clinical Decision-Making – CareOregon did not appropriately auto-forward a coverage determination exceeding the CMS required timeframe to the IRE for review and disposition. CareOregon failed to recognize when the initial coverage determination was received that it was marked as urgent. CareOregon lacks adequate controls for tracking incoming coverage determination requests. The failure to forward cases to the IRE in a timely manner can result in delays of access to care. The beneficiary may also be confused regarding the status of the determination.
5. Part D Coverage Determinations and Appeals, Appropriateness of Clinical Decision-Making – CareOregon included inappropriate structural context in the determination notices to the beneficiaries. CareOregon's notices included grammatical errors, clinical acronyms without definitions, missing words, and limited information (e.g. exclusive of all alternative medications and related conditions). CareOregon lacks adequate controls to ensure the context of the determination notices is accurate and appropriate. CareOregon should enhance controls to ensure determination notices include accurate and appropriate information.

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 Ms. Holly Robinson at 206-615-3673 or via email at Holly.Robinson@cms.hhs.gov.

Sincerely,

/s/

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